Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department / Depart	artment of Health and Me		21110	15501
		Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	g. No:	3. Time of Death
Physici	an	Julia Vivian Wilkes		Month	Day Day	125A M
/Medic	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ypu	4c. County of Death	
Examir	ıer	Coffman Nursing Home	Hagerstown		Washington	n County
Funeral	_	5. Social Security Number 6. Sex y 7. Age (In yrs. last birthday)	If Lindor 1 Voor If Linder 24 Hrs	8. Date of Birth (Month, Day,	9 Right	nplace (State or Foreign untry)
Director		214-09-1449	A	pril 12	,1913 Mar	yland
p s		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lity	ocation			10d. Inside City Limits
Aaryk Febo	ō	Maryland Washington County Hagersto	านท			1 □ Yes 2 No
the the 288-	rect	10e, Street and Number	10f. Zip Code	10	0g. Citizen of What Co	untry?
3a or	Funeral Director	1304 Pennsylvania Ave.	21742		U.S.A.	
deatl	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
after after	Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No	1 ☐ Yes 2 No Specify:		Specify: W	hite
1215-0036 within 72 hours after death with the Maryland sne. sne. rhan "natural", or items 23a or 28a-f ehow na Madical Exempliner, and be notified at	d by	3 Widowed 4 Divorced Year or Dates:	edent's Usual Occupation		16b. Kind of Business/	Industry
15- n 72 n 72	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of workin DO NOT use retired)	ng		
Mithing Indian	mo	Elementary/Secondary (0·12) College (1-4 or 5+) 1 Booke	eeper		Office Sup	ply
nd 2121 e fited within al Hygiene. I other then '	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	Maiden Sumame)	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. T ie marked other than "natural", or traumatic event, the Medical Exemi	To E	Clarence V. Wilkes	Lottie E			
nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan 11 of Health and Mental Hygiene. 11 if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational Legicilies at			ing Address (Street and Number or Rura)			
P, N I and Health om 27	8	20h. Place of Disp		1111ams ate	PORT, MU Z 20c. Location - City or	1795 Town, State
Baltimore, permit. Pages 1 at Department of Heal Important: If Item any injury or otherman.		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State	ematory or other place)	- 1		
Baltimo Permit. Page Department of Important: if Inny injury or		4 □ Donation 5 □ Other (Specify) Smithsbu: 21. Signature of Funeral Service Licensee	rg Crematory 4-22- 22. Name and Address of Facility Dou	·2008	Smithsburg Fiery Fun	eral Home
Bal permin Depa Impo	+		1331 Eastern Blvd.			
		23a, Part 1. Enter the disease, or complications that caused the death. Do not en	nter the mode of dying, such agreardiac o	r respiratory arr	est,	Approximate Interval Between
Physician		shock, or head allure. List only one cayse on each line.	Whitale dinet	(ISE)		Good Seath
/Medical		disease or condition resulting in death) a. Due to (or as/3 consequence of):	free good	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_	7/arlow 8
Examiner		Sequentially list conditions. b. Murubulary	sesson		/	10 peacs
p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	10		-	10Mones
60, be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	~/			(pur
760, te be executed ysicien and te burial-transit	calE					
9 % 0		0.				<
Box 68 leath certificate ettending phy	N/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of de	
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the ettending ph age 2 should be detached for use as it	Physician/Med	in the past 12 months. 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
p.O. I	Phys	9 LJ Unknown	de tributa de la compania Dant I	23e Did to	bacco use contribute t	o the cause of death?
igned	þ	Part II. Other significant conditions contributing to death but not resulting in the	I H M	1 □ Y		robably 4 Unknown
cord	eted	Topasson copperation		24a. Was	an 24h Were a	utopsy findings available
Vital Records, sician: The law requires to certificate has been signe rector, page 2 should be	Completed			autop perfor	sy prior to death?	completion of cause of
			26, Place of Death		2 1 Ye	s 2 No
	o Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpati	Other		lence 6 Other (Sp.	ecify)
	n: To	27. Manner o h 28a. Date of Injury 28b. Time	of 28c. Injury at		now injury occurred	
Vision of Attending I redeath.	atio	2 Accident investigation	M 1 Yes 2 No			
Division Tor Attending after death. Director: After Sin by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
Doital or aff					enuse(s) and manner	us stated
Divisit To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	edicai	29a. Certifier 1 ertifying Physician: To the best of my knowledge, de (Check orly one) Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	red at the time,	date and place, and du	e to the cause(s)
o the omple	Med	29b. Signature) and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
F 3 F 8		Amust (hasten)	036655	#	April 21	2008
101		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		22.10	,2008
P D		324 East ANTIETAM SI. MILE	200- Migustow	y mo	1140	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	A - 10 -	,		
Regis	trar	APR 2 5 2008				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryla 1-State Registrar WCHD/SH 4/30/08 per FH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 22 2008 **Physician** Rodney Austin Walser 4:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County 13518 Spring Hill Drive Hagerstown 5. Social Security Number 200–16,–442 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Yrs. Director Sept. 30,1922 Pennsylvania 85 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM-Dical Examinar must be notified at once. 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 13518 Spring Hill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No White ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Chemical Co. Works Control Superintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Frederick Walser Theresa Schwartz Walser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda Walser-wife 13518 Spring Hill Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Smithsburg Crematory 4-24-2008 | Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses aittin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Cerebrove Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to for as a consequence offs Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of deeth
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar MIChael //
31. Date filed (Month, Day, Year)

APR 2 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

netk

32 Registrar's Signature

			For State	State of	of Marylan		rtment of H		lental Hy	giene			~ () ()
			Registrar	(4)		Cer	tificate of l	Jeath	2. Date of De	Reg. No.	108	3. Time	of Death
Г	Physicia		1. Decedent's Name (First, Middle, BLANCH WILL		ALTERS				Month MAY		00 ^{Year}	8:4	
	/Medic Examin	-	4a. Facility Name (If not institution,	-				Location of Death			ty of Death		
مات ا			Chestertown N				Cheste	ertown If Under 24 Hrs.	8. Date of Bird	Ken		olace (State	or Foreign
ì.	Funeral Director	-	5. Social Security Number 213-09-8076	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs. 96	Yrs.	Months Days	Hours Min.	Jan 23	1912	Mary	land	Orroneign
[2]	D		Usual Residence of Decedent		1						1.	10d. Inside	City Limito
	arylan show d at	Ļ	10a. State 10b. County MD Kent			y, Town or Lo alena	cation				[s 2 No
	he Ma 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?	
	N with 1	al Dir	12750 Irelan	ds Corn	er Rd.		2163	5	:	ŭ.s.			
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, them "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed F ed 1 □ Yes If Yes, G	2⊠ No live		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔯 No	Ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	ВІ	ace - Americ lack, White, cify: Whi	etc.	
ğ	hours tural	ed b	15. Decedent's	Year or I s Education	- 31	16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/In	dustry	
215	hin 72 e. an "na Medik	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done of NOT use retired		king		. •		
7	ed with	Com	11			Owne	r-Opera		- (Ei-1, 14) state	Farm			
Maryland 21215-0036	ntal Hy ed oth	Be	17. Father's Name (First, Middle, L George Willi					18. Mother's Nam	Nicker		ame)		
ž	should od Mei mark matic	은	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zi	p Code)	
	and 2 saith ar		G. Richard W	Valters			0 Irela						21635 ———
Baltimore,	yes 1 g	l i	20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from			nsition (Name of matory or other place		Date 9 / 08	20c. Location			
Ħ	t. Pages rtment of I rtant; If ite		4 ☐ Donation 5 ☐ Other (Sp	ecify)	G		Cemeter						
Ba	permit. Page Department of Important: If any Injury or once.		21. Sign thre Tuneral Service L	Cl		510 11	2.Name and Addre alena Fu 18 West	Cross S	St. Gal	ena,	hen I	21635	
H		A 10	23a. Rart1 Enter the disease, or o	complications that only one cause on					or respiratory a	ırrest,		Approxim Interval E Onset an	d Death
	Physician /Medical		Immediate Cause/(Final disease or condition resulting in death)	a. Nue tr	o (or as a consec		C CAL	PER			-	Ima	nth_
	Examiner			Due	o (or as a consec	querios oi).							
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to	o (or as a consec	uence of):							
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	uence of):							
8760,	icate be executed physician and s the burial-transit	dical E			(, ,							
9	tificate g physas the	ledic	-	u.									
30X	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregn birth 2 ☐ Fet		∃Ectopic pregnanc	у			Date of deliv	very Day	Year
Vital Records, P.O. Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of a known	death 5[Other (specify) _					,	
آ	that the	/ Ph	Part II. Other significant conditio	ns contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ontribute to	the cause o	of death?
Sp	quires n sign uld be	d by							10	Yes 2 No) 3 ☐ Pro	bably 4	□Unknown
000	law re as bee 2 shoi	Completed							24a. Was		b. Were aut	topsy finding	gs available if cause of
Ĕ	The ate his page	Som							perf 1⊟ Yes	2 No	death? 1 ☐ Yes	25 No	
Vita	Ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of Dea				-	
0	Attending Physician: The laver death. rector: After this certificate has by the funeral director, page 2	٦.	1 ☐ Yes 2 No 27. Manner of Death		☐ Inpatient 2☐ te of Injury	28b. Time of	nt 3 DOA	4 Mursing F	lome 5 ☐ Res	idence 6 🗆 o		eify)	
0	nding th. :: Afte e fune	ntion	Natural 5 ☐ Pending 2 ☐ Accident investig	g (Mo	onth, Day Year)	Injury		rk? ∐Yes 2∐No					
Division or	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 28e. Plac	ce of injury - At h	nome, farm, st	reet, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or Ru	ral Route N	umber,
	nital or Ins aft rral Di			1/14			N	in a data and alassa	and due to the	a name (a) and	menneres	etated	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Check only one)	Examiner: On the	ne best of my kn basis of examin anner stated.	ation and/or i	th occurred at the to nvestigation, in my	opinion, death occ	urred at the time	e, date and plac	ce, and due	to the caus	se(s)
	To the Within To the	Me	29b. Signature and title of certifier		, ,		29c. Licens			29d. Date sig	ned (Month		r)
			> thut	When	MUS)	D	00415	87	5	16	08	
			30. Name and address of person										
			Helen A. 31. Date filed (Month, Day, Year)	Noble,	M . D . Registrar's Sign	122 S	peer Rd.	. Cheste	ertown	MD.	21620	U	
	St: Regist	ate rar	RATV 1 0	AT .	The gistral 3 olgi		20						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Me	•	Certificate of			Reg. No. 2	9 15501
	Physici	_	1. Decedent's Name (First, Middle, Las Florence		olfe			2. Date of Dea Month 04	Day Yea 30 2008	3. Time of Death r
)	/Medic Examin		4a. Facility Name (If not institution, given Dennett Road Mane	e street and number)		4b. City, Town, o	r Location of Death		4c. County of De	eath
ď	Funeral Director		Social Security Number 6. S		90 Yı	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 03/24/	h 9. E	Birthplace (State or Foreign Country) WV
	f show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 □ Yes 2 ☑ No
	h with the N 3a or 28a- st be notifi	al Director	MD Garrett 10e. Street and Number 5915 Cransville		Uakiai	10f. Zip Code 2155	0		10g. Citizen of What	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 1 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No		ecify Yes or No Rican, etc.)	Black, W	merican Indian, hite, etc. White
21215-0036	vithin 72 hol ne. han "natur e Medical E	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of work d)	sing	16b. Kind of Busines	ss/Industry
lang z	ild be filed v tental Hygie ked other t ic event, th	To Be Col	8 th 17. Father's Name (First, Middle, Last Samuel G. Wilson		l n	OUSEMITE	18. Mother's Nam		Maiden Surname)	
, Maryland	and 2 shou salth and M 27 is mar er traumat	-	19a. Informant's Name/Relationship (**	d 5	Mailing Address (Street 915 Cransv:	ille Rd. (Dakland	, Maryland	21550
Baltimore,	Pages 1 tment of He tant: If iten jury or oth	107	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)		Disposition (Name of crematory or other plate)	ry 05/0		20c. Location - City Lake Ford uneral Hom	, Maryland
Pa	permit Depar Impor any in	9 47	21. Signature of Funeral Service Lice	Levar		32 South	Second St	reet Oa	kland, MD	
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A/Zh	the death. Do not not not not not not not not not no	den	1	or respiratory a	rrest,	Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	b Due to (or as	a consequence of):				
68/60,	tificate be executed ig physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of	i):				
O. Box 68	death cer e attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	Sy		23d. Date of Month	delivery Day Year
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or Vital Records,	ate Pag	Completed					<u> </u>	24a. Was auto perfo 1 Yes	an 24b. Were prior death	e autopsy findings available to completion of cause of h? (es 2000
VIta	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩6	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Out	patient 3 DOA Ot	26. Place of Dea her: 4 Nursing H		one idence 6 □Other (S	Specify)
Division o	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident 3 Suicide 6 Could not t 4 Homicide determined	e 28e. Place of ini	y Year) In	jury Wo]Yes 2□No	28f. Location (how injury occurred Street and Number of wn, State)	r Rural Route Number,
ă	Hospital or 24 hours afte Funeral Dir tely filled in	Medical Cert	29a, Certifier 1 2 ertifying P	hvsician: To the best	of my knowledge, f examination and	death occurred at the l/or investigation, in my	time, date and place opinion, death occu	, and due to the	cause(s) and manne	r as stated. due to the cause(s)
)=	To the within 2 To the comple	Med	29b. Signature and title of certific	and marmer sta		29c. Licen	se number		29d. Date stigned (M	lonth, Day, Year)
		6	30. Name and a less of person who Sotiere Sovopou				1, MD 2155	50	1 /	
	St Regist	ate	31. Date filed (Month, Day, Year) 05/02/2008	22 Majetr	ar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mary Alice Yacenech May 01, 2008 6:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Min 1 □ M 2 🕱 F Hours Director 220-16-5565 West Virginia May 06, 1914 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits rral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 □ No Director Maryland Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Winifred Road 21502 U.S.A Funeral death . 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Tire Maker Tire Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Yacenech Katherine Hnatyk ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15801 Downing Street, Cumberland, Maryland, 21502 Roberta See - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 02 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cumberland Crematory 4 □ Donation 5 □ Other (Specify) 2008 Cumberland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street, Lonaconing, Maryland 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 405 **Physician** Corona /Medical Due to (or as a masequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the l IF FEMALE for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 cate has been signification of the category and page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 2 No 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1-EX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

Dr. Sunil

31. Date filed (Month, Day,

29b. Signature and title of certifit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Guota Mo

628 Kent Avenue

32. Registrar's Signature

29c. License number 000 33 280

Cumberland, Maryland

May 2, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1, Decedent's Name (First, Middle, Last) Month Year **Physician** 10 h Mary 2000 1092 4a. Facility Name (If not institution, give street and number) Auzenshtadt /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Social Security Number 1391 Huras Kon de IISto wn If Under 1 Year | If Under 24 HOSO, 101 Cluster 9. Birthplace (State or Foreign Country) UKRAINE 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 1 M 2 F **Funeral** 08/10/1918 Days Hours 89 219-19-0426 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show notified at 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hydjene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-unt or other traumatic event, the Medical Examiner must be notifit 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6986 MILBROOKD PARK DRIVE, APT. 1-B 21215 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WHITE 1 ☐ Yes 🖈 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MILITARY OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN **AYZENSHTADT** SARA VIADIMIR ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) 6986 MILBROOK PARK DRIVE, APT. 1-B, BALTIMORE, MD SOFIA POVADATOR / WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition CATPATERY NIGHTATORY OF other place, CHIZUR AMUNO CONG. permit. Pages Department of Important: If it any Injury or o 1 M Burial 2 □ Cremation 3 □ Removal from State 05/11/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Malt /euls 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician day Colonic Obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner months METERNATIC Colun Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to for as a consequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 25 No 1□ Yes 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Uppatient ို 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1-ANatural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO056632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAY 13 2008

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Liudmila Semenovna Byalaya 4:00 A. M 2008 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 3601 Fords Lane Apt. 119 8. Date of Birth (Month, Day, Year) March 15, 1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country). Ukraine 218-49-2265 1 M 201 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a. State Baltimore 1X Yes 2 No Baltimore Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 21215 United States 3601 Fords Lane Apt. 119 America

14. Race - American Indian within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher is 1 and 2 should be filed voil Health and Mental Hygie Item 27 Is marked other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Ruckaya Semen Grigorenko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) 3601 Fords Lane Apt. 119 Baltimore, Maryland Vilen Byalaya/ husband permit. Pages 1 ar Department of Hea Important: If Item 3 any injury or other 20b. Place of Disposition (Name of May 14, 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place)
Evans Funeral 1 ☐ Burial 2√ Cremation 3 ☐ Removal from State Forest Hill, Maryland 2008 4 □ Donation 5 □ Other (Specify) Chapel- Bel Air 21. Signature of uneral Service License 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimers **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the bunal-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death been signed by the sahould be detached to Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diusetes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No r this certificate has ral director, page 2 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 1 D Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

State

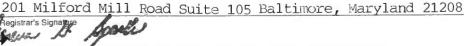
32 Registrar's Signature 31. Date filed (Month, Day, Year) 2008 Solder MAY 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lexande

29b. Signature and title of certifier

Dr. Daniel Alexander



29c. License number

D52815

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MAY Charles Gordon Bowers, Sr. 11 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MD BALTIMORE Baltimore CENTER CROMWELL GENESIS 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 1 M 2□F 219-01-4445 March Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ms 23a or 28a-f shov must be notified at Parkville 1 ☐ Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 2824 Garnet Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or item Examiner 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lucas Brothers permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Magnee. College (1-4or 5+) Elementary/Secondary (0-12) 12 Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen L. Murphy Herbert C. Bowers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2824 Garnet Rd. Parkville, MD 21234 Constance O. Bowers/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition moreland Memorial 05/16/08
Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or he int failure. List only one cause on each line. Immeriate Cau le (Final diser se or condition END **Physician** STALE DEMENTIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 - No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ № 6 Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Natural 5 Pending investigation 1 TYes 2 TNo death. 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifiei 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 77GNDING 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOD60039 PHYSIC, AN MAN. N DO, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 N. CHALLES 4202 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 13 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMN TIPM/5, perFH 080,6/5/08 NS
State of Maryland "Department of Health and Mental Hygiene" [] [] [] 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11.45 P.M. R. Booth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day NOV. 27 5. Social Security Number Birthplace (Stete or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F U9-82-8312 92 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 7572 Beach Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmella Marsiglia Antonio Marsiglia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laura Bertram (grandaughter) 7572 Beach Drive, Pasadena, MD 21122 May 1 2008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) New Cathedral Cem. Baltimore, Maryland 21. Signature of Funeral Sc rvic License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) senmoniA a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Causa (Dicease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Physician /Medical Examiner Box 68760, Division of Vital Records, P.O.

physiclen and the burial-transit The law requires that the death certificate be executed the use as ģ à Hospital or Attending Physician: veral Director: After this certific filled in by the funeral director. within 24 hours after death. To the Funeral Director: Al

Physician

/Medical

10a, State

Director

Completed by Funeral

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Examine

Physician/Medical

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Completed

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Certification:

cal

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Examiner

Funeral

Director

item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

Department of Health a important: if item 27 is any injury or other traisons.

State Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month Day 10:05AM **Physician** Brown ames 2008 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner xaltimore 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 212-22-991 Months Days Hours Min 1 M 2 F ጸ Director Usual Residence of Decedent 10a State 10d Inside City Limits 10h County 10c. City. Town or Location th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be mothed at **Funeral Director** Baltimore 1€ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2121 arter 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Tes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No If Yes, Give Year or Dates Specify Completed by Specify: Black 3 ☐ Widowed 4 ☐ divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown Bertha Johnson ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is eny injury or other trau once. Florence Brown Winters Lane Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State 5/13/2008 Baltimore, Mi) King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4905 York had Bultimore MD 21212 21. Signature of Funeral Service Vaughn C. Services

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PROSTATE CANC monet NETASTATIC disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 🗆 No 1 ☐ Yes 2 100 or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 University Home 5 Residence 6 Other (Specify) After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

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21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> HALLUN MAC

MAY 13 2008

31. Date filed (Month, Day, Year)

GUPTA

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 4:10 р. м Year 2008 **Physician** Bernice Beatrice Brooks May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore 2329 N. Monroe Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7–12–1931 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🛛 F MD 21.8-26-5600 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Control of the cont 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Yes 2 □ No Director n/a Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2329 N. Monroe Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: African-American 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles M. Hillery Geneva Carter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2329 N.Monroe Street, Baltimore, MD 21217 Jessica R. Carr/ Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-15-08 Arbutus, MD Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Fineral Fame F.A. of Balto. Co. of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mose shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 40 Cend /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has page 2 s autopsy performed? Yes 2 certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: this c 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 25716 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) Director: After the in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 D Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospina.
within 24 hours after
To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medican xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

State Registrar Signature and title

and address of per

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31. Date filed (Month, Day, Year)

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ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

FLAN

29c. License number

				For State Registrar	State of Ma	arylan		artment r <i>tificate</i>			and M		giene Reg. No.(2008	3	1551	2
				1. Decedent's Name (First, Middle, L	ast)							2. Date of De	ath	Yea		3. Time of Death	
		Physicia /Medic		William E. Brov	vn							May 10,	200	8		10:05 P	M
	7	Examin	er	4a. Facility Name (If not institution, g				4b. City, To			of Death		1	County of De			
	and high			Stella Maris Hosp		. //	1 t-1t1 N	Luthe		II Under	24 Hrs T	8. Date of Bir		ltimo		e (State or Fore	ian
		Funeral		5. Social Security Number 6. 215–03–4431	Sex 7. Age	93	last birthday) Yrs.		Days	Hours	Min.	05/21/1	y, Year) 914		cyla) _	gn
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		yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d.	Inside City Lim	
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		er de Items ner n	٦	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent I		31_	was Decede If Yes, specif	fy Cubai	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	· '	Black, Wi			
	936	urs an	P	3 Widowed 4 ☐ Divorced	Armed Forces? ★天子es 2 □ N If Yes, Give Year or Dates:	19	35	1⊡Yes %	No.	Specify:	:			Specify: Wh	nite	2	
p-m-	0-9	illed within 72 hours after death with the Maryland Hygiene. When than "natural", or Items 23a or 28a-f show ent, the Modical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual	Occupa	ation	et of worki	na		d of Busines			
D D	21	thin /	nple.	Elementary/Secondary (0-12)	College (1-4or 5	+)	1	kind of work DO NOT use	retired))	A OI WORK	9		imore ce De			
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10	anc	ntal H ed ot	Be	17. Father's Name (First, Middle, La Frank Brown	st)					Anna	_		iviaiden (<i>Surriame</i>)			
∞	Z	mark matic	은	19a, Informant's Name/Relationship	(Type, Print)		19b. Mailii	na Address ((Street a			al Route Numb	er, City or	Town, State	e, Zip C	ode)	_
2008	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Destinent of Health and Mental Hygiene. Important: If lem 27 is marked other than "naturali", or liems 23a or 28a-f show any Injury or other traumatic event, the Mortical Examiner must be notified at once.		Patricia Schech								Baltim					
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u		/Medical Examiner		resulting in death)	Due to (or as	a consec	juence of):										
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		To the poster or attending registrant, the within 24 hours are death. To the Funeral Director: Affar this certificate h completely filled in by the fun rail director, page		29a. Certifier 1 X Certifying	Physician: To the best	of mu kn	nwledne deel	th accurred a	at the tim	me date o	and place	and due to the	cause/e	and mence	r as eto	ted.	
	į	no the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one)	enysician: To the best aminer: On the basis of and manner st	f examin	ation and/or ir	nvestigation,	in my o	pinion, de	ath occur	red at the time	, date and	place, and	due to t	he cause(s)	
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		ļ		DR. ERNESTINE W	RIGHT 2300	DUI	LANEY V		RD	. TI	MONI	UM, MD	2109	3			
		Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Sign	ature	all s									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eleanor Mary P2 В. Brown 2008 4:59 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1813 Blakefield Circle Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 21, 1922 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Months 85 218-14-0505 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show iral", or items 23a or 28a-f sh Examiner must be notified Md. Baltimore Lutherville 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 Blakefield Circle 21093 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. In the flem 27 is marked other than "natural", or itel my or other traumaft event, the Medical Examine. my or other traumaft event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Shipley George A. Bratt, Jr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 949 Fell St. Baltimore, Md. 21231 Mr. S.A. Brown, III/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Service Co. 5-13-08 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastnic adenocancinoma **Physician** ine months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknow s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) death. 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 687600 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

Registrar

31. Date filed (Month, Day, Year) MAY 13 2008

Manstroll A. 1

29b. Signature and title of certifier



of person who completed cause of death (Item 23a) (Type, Print)

nombella Time, M.D.

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Charles St. Ba Himone, Manyland 21204

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 19b, perFH,G879 5/13/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MORRIS 2008 BRICKEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN Birthplace (State or Foreign Country) NV 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, Year) 10/11/1912 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 XM 2 □ Days 578-03-4426 95 NY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner coast be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21208 3605 WOODVALLEY DRIVE USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or WHITE 1 ☐ Yes 2 No Completed by If Yes, Give Year or Dates Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Coilege (1-4or 5+) Elementary/Secondary (0-12) CLOTHING MANUFACTURER OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta BRICKEN UNKNOWN DAVID HINDA Injury or other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3605 WOODVALLEY ROAD, PIKESVILLE, MD 21208 19a. Informant's Name/Relationship (Type. Print) BERNICE BRICKEN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 □ Burial 2 □ Cremation 3 □ Removal from State 05/11/2008 BALTIMORE HEBREW REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS. MD INC. 21208 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rostate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ce ificate 2 3 No 1 ☐ Yes 2 110 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No hours after death. Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 10th 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIETCE 25 MAIN STRET REISTONSTOWN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

MAY 1

Year)

3 2008

Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Please Type or Brint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12, **Physician** Month 2008 Louis J. Cantori Jr. 10:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 716 Dryden Drive N/A Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1034 | Months | Days | Hours | Min. | Month, Day, 1034 | JUN 29 1039 6. Sex 1**X** M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 68 Massachusetts **Director** 024-26-6581 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 716 Dryden Drive 21229 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event. The Medical Ferralments. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Xes 2 No
If Yes, Give 1051 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White Specify. ģ rear or Dates: 1951-55 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ပ Cantori, Sr. Catherine 0'Shea 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Cantori, Wife 716 Dryden Drive, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Funeral Service Licensee

Steven H. Williams Metro Crematory, Inc. 5/13/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility

Cremation Society of Maryland,
299 Frederick Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Crediac Scuile 40415 /Medical Due to (or as a consequence of) Examiner Yin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) o. ☐Yes 2☐No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Actory Colonary Discase 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performe 2 ☐ No 1XYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 00 54717 13/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kameen Molari MP 10755 Falls Road, Lutherville, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav 12:50 P M **Physician** CHAMRERS 05 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) ty, Town, or Location of Death Examiner and All Stown Baltin 70re Future Od 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 216.18.993 1 □ M 2 💢 F MD 85 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 28a-f show d other than "natural", or items 23a or 28a-f showevent, the "Addral Examiner must be notified at Baltimone 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 3521 Meadowside Road 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any fujury or other traumatic event, the Medice. Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tasker **Estella** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter-5701 Gwynn Dak Avenue Baltimore MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Woodlawn, MD 05/16/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility Vallann C. Greene Funeral Services 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Road Randalistown MD 21133 Immediate Ceuse (Final disease or condition resulting in death) CANCER **Physician** METASTATIO UNG MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐Yes 2 █ Ño 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Ves 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

34

State RegistrarM. VASANTUA KUMAN S

31. Date filed (Month, Day, Year)

MAY 1 3 2008

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

asantalama un

516 N. ROLLING ROAD

	within 24 hours a To the Funeral I Completely filled	Medical Ce
	Reg	State istrar
DHM	H 17 Rev	/ 1/2001

	For State Registrar	State of N		d / Depa		of H					200	8 55
Physician /Medical Examiner	Decedent's Name (First, Middle, Las. Melvin J 4a. Facility Name (If not institution, give	. Cerny	r)		4b. City,	Town, or	Location	of Death	2. Date of De Month	MAY	Year 8, 200 County of De	28 8:38F
uneral rector	Saint Joseph 5. Social Security Number 6. Se 212-20-4401			ter last birthday) Yrs.	If Under Months	1 Year Days	if Under Hours	OWS 24 Hrs. Min.	8. Date of Bin (Month, Date Aug. 1	th 3, Year) 3 19	9. B	ltimore inthplace (State or Forei Country) and
	Usual Residence of Decedent 10a. State 10b. County Md. Baltimo	re	10c. Cit	y, Town or Lo								10d. Inside City Limi
23a or 28a-f sl ist be notified al Director	10e. Street and Number 2 Thrush Court			-	10f. Zip	Code 21093	3			10g. Citiz	en of What C	Country?
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 X Yes 2 If Yes, Give Year or Dates] No		1 □ Yes	No 🏝	Specify:		ecify Yes or No Rican, etc.)		Black, Wr Specify: Wh	i te
t, the Medical Exar Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4o	r 5+)		kind of wor DO NOT us Ck Dr	k done d e retired,	luring mos			St	eel	s/industry
arked oth atic even To Be	17. Father's Name (First, Middle, Last) Frank Cerny						Anna	Pi	e (First, Middle Ch			
m 27 is m her traum	19a. Informant's Name/Relationship (7 Mrs. Cathy Kalish			1 +	Turli:	ighar	m Cou	rt B	al Route Numb altimo	^e, M	d. 212	208
ant: If ite	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			Place of Dispo cemetery, crei uid Ri				-13-	08		,	e, Md.
any inj	21. Signature of Funeral Service Licens	500		22	1050	Tows York	sof Facility	uner Tow	al Home	i. 21	c. 204	
sician edical miner	23a. Part1. Ent_r the disease, r comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. CARD Due to (or a	i line. I OMYC as a conseq	PATHY juence of): VIC SH	,	e of dying	g, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
attending physician and for use as the burial-transit cian/Medical Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							_			
by the ached	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of c	al death 3	∃Ectopic pr ∃Other <i>(sp</i>					2	3d. Date of c	lelivery Day Year
be d	Part II. Other significant conditions of HEART FAILURI	Ξ	but not res	ulting in the u	nderlying c	use give	en in Part					to the cause of death? Probably 4 Unknow
ate has page 2	RENAL FAILUI	RE							24a. Was auto perf 1∐ Yes		24b. Were prior t death	autopsy findings availal o completion of cause o ? es 2/11No
To the Funeral Director: After this certificate completely filled in by the funeral director, pag. Medical Certification: To Be Co.	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of In (Month, I	njury Day Year)	ER/Outpatier 28b. Time o Injury ome, farm, str	f 2	8c. Injun Work	er: 4□N	ursing Ho		idence 6 how injury	occurred d Number or	pecify) Rural Route Number,
or the Funeral ompletely filled	29a. Certifier (Check only one) Certifying Phyone	ysician: To the be iner: On the basis and mappier	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the red at the time	cause(s) , date and	and manner place, and d	as stated. \ ue to the cause(s)
Comp	29b. Signature and title of certifier	Th			290	License	number 356			29d. Date	e signed (Mo $^{\prime}$	nth, Day, Year) 2-008
State	30. Name and address of person who of KHOSROW TABASS 31. Date filed (Month, Day, Year)	32 Regi	76 Ø 1 strar's Signa	OSLE	R DE	IVE	TOL	ISON	MAR	(LANI) 212	214
Registrar	MAY 1 3 200	18	as h	× Ap	whi							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State State Registrar	or Maryland	Certificat		th	Reg. N	0000	15520
165	Physicia	_	1. Decedent's Name (First, Middle, Last)	aheru	a sol			ate of Death onth D	ay Year	3. Time of Death
Vine in	/Medic		4a. Facijity Name (If not institution, give street and		- 14	Town, or Local	tion of Death	4	c. County of Death	1110 1
-	e April	46	5. Social Security Number 6. Sex	7. Age (In yrs. la	est hirthday) If Unde		nder 24 Hrs. 8. Da	ate of Birth	9. Birth	place (State or Foreign
	Funeral Director		560-87-1007 1₹ M 2□		Yrs. Months	Days Hou	irs Min. (N	11 , 19) Cou	ran
	fand ow if		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
	e Mary a-f sh tifled a	ctor	MD		Baltim	ore				1√ Yes 2 No
	h with th	Funeral Director	10e. Street and Number 1905 Aliceanna Street		10f. Zi	21231		10g. C	itizen of What Cou	intry? unk
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year	Decedent Ever in U.S d Forces? es 2 ANo , Give or Dates:	1 ☐ Yes	2 X No Spe	c Origin? (Specify Y exican, Puerto Rican ecify:	1	14. Race - Amer Black, White Specify: W	, etc. hite
21215-0036	within 72 hene. than "nate	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Unk 15. Decedent's Education College Grade Complete College Colleg	ge (1-4or 5+)	16a. Decedent's Usu (Give kind of w life. DO NOT u	ork done durina	most of working	100.	Killid of Business/ii	industry
Maryland 2	ould be filed v Mental Hygie narked other t natic event, th	To Be Co	17. Father's Name (First, Middle, Last)		u	18. N	Mother's Name (Firs	t, Middle, Maide	en Surname)	unk
lary	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Type. Print)		19b. Mailing Addres					ip Code) 225
	1 and Health tem 27 other tr		Harbor Hospital 20a. Method of Disposition	20b. Pl	ace of Disposition (Na emetery, crematory or	me of	Street B		Location - City or	
Baltimore,	Pages ment of h ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify) in	rom State				N		
Balt	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		21. Signature of Funeral Service Licensee Ronal S. Wade	Director		nd Address of Anatomy nore, MI	Facility y Board 6 D 21201	55 W. B	altimore	Street
	Physician		23a. Pa 1. Enter the dis ase, or complications t sh tk, or heart failure. List only one cause Immediate Cause (Final disease or condition	on each line	Do not enter the mo	4				Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	e to (or as a consequ						
1		Jer	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying	e to (or as a consequ	rence of):					
	recuted and -transit	Examiner	Cause (Disease or injury that initiated events c	e to (or as a consequ	gence of):					
68760,	icate be executed physician and s the burial-transit	edical E	d				, , ,			
.O. Box 68	ath certif ttending or use as	Physician/Medi	in the past 12 months?	s, outcome pf pregna ive birth 2 □ Fetal Pregnant at time of de Inknown	death 3□Ectopic				23d. Date of del Month	ivery Day Year
0	that ad b	by	Part II. Other significant conditions contributing	to death but not resu	alting in the underlying	cause given in	Part I.			the cause of death?
Records,	e law has b je 2 sh	Completed				. —		24a. Was an autopsy performed 1□ Yes 2	prior to death?	utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	- 1		Other	Place of Death (Ch			
ō	Phys r this ral dir	<u>۲</u>		Date of Injury	ER/Outpatient 3 ☐ 0 28b. Time of	28c. Injury at Work?	☐ Nursing Home 28d.	5 Residence Describe how in		cify)
Division	i or Attending Fafer death. Director: After lin by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28e.	(Month, Day Year) Place of injury - At hobuilding, etc. (Specify	Injury M ome, farm, street, factory)	1 ☐ Yes	28f. I	ocation (Street City or Town, St	and Number or Ri ate)	ural Route Number,
۵	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: 1 Certifying Physician	the basis of examina	wledge, death occurre	ed at the time, d	late and place, and on, death occurred a	due to the cause t the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
	ro the within 2 Fo the complex	Med	29b. Signature and title of certifier	manner stated.	2	9c. License nur	mber	29d.	Date signed (Mont	th, Day, Year)
			am I Nan	Edu.	40	0745	32	4	pril 2	8006,
			30. Name and address of person who completed	- 1	1 23a) (Type, Print)	15. 4	languar	St B	e /timo	1,2008 21275 M&
0	St	ate	31. Date filed (Month, Day, Year)	7. Registrar's Signa	ature		,			/

DHMH 17 Rev 1/2001

08-03513
Aria Dennis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

15521 2008 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 8, 2008 Medical Examiner 0054 hrs via ennis 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 5712 Gist Avenue **Baltimore** N 9. Birthplace (State or Foreign Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Days Country) Director М Yrs Usual Residence of Decedent tny 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore 1 XYes 2 No the Medical Examiner must be notified at once, Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5712 USA 21215 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 5 Yes, Give Year Yes 2 No specify: Black Widowed Divorced Specify: <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7: Oppartment of Health and Mental Hygiene. item 27 is marked other than Ketail Helemarketer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nolan mai 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) + Belleville Avenue Mother latimore MD 21207 Method of Disposition 20b. Place of Disposition (Name of cemetery, Date tant: If it Burial Cremation 3 crematory or other place) 2 Removal from State 05/16/08 Munorial Donation 5 Other Specify: 22. Name and Address of Facility Vaughn C. Green Funeral Svcs. 21. Signature of Funeral Service Licensee allown 23a. Part I. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and Randallstown MD 21133 Approximate Interval Between Onset and Physician failure. Lat only one cause on each line. /Medical Death Complications of sustemic lurus erythematosus Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical #23a,27,perME,g879 Iten#22,perFH,G879,5 ′08 TT attending physician for use as the burial -X UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown q Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> No 3 Probably 4 ✔ Unknown Yes 2 Completed peen page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 2 No No 1 🗸 Yes the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ After this c ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 Yes Inpatient 2 ٩ No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: d in by the f Yes 2 24 hours after death. Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical the] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ٥ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 8, 2008 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State

9 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	f Maryland /		artment of H rtificate of L				ene ()	08	15522
	Physicia	_	Decedent's Name (First, Middle Henry Evans						-	nate of Death Month May		OSer OS	3. Time of Death 7:09 PM
	/Medic Examin		4a. Facility Name (If not institution		mber)		4b. City, Town, or	Location of		,	4c. County		
	Examin	eı	Anne Arundel				Anna	polis	3		Anne	Arun	del
	Funeral		5. Social Security Number		7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under Hours	24 Hrs. 9	Date of Birth	Year)	Cou	place (State or Foreign ntry)
	Director		139-32-5594 Usual Residence of Decedent	AW ZUF	66	Yrs.			IN IN	lov 3,	1941	New	Jersey
	land w		10a. State District of 10b. County		10c. City, Tov	vn or Lo	ocation						10d. Inside City Limits
	Many B-fsh	tor	Columbia N/A		Wash	ing	ton						1 XYes 2 □ No
	or 28)ire	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	ntry?
	ath w	rai	1237 Delaware A				200				USA		
	er de Items	Funeral Director	11. Marital Status	Armed Fo	edent Ever in U.S. proes?	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Ori n, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		ck, White,	can Indian, , etc.
336	filed within 72 hours efter death with the Maryland Hygiene. sther than "natural", or Items 23a or 28e-f show ant, the Medical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💢 Divorced	II Yes. Giv	/8		1 ☐ Yes 2 🂢 No	Specify:			Specif	y: B1	ack
9	72 hou	ted		t's Education st grade completed)	168	. Dece	dent's Usual Occupa	ation	t of working		16b. Kind of B	usiness/1r	ndustry
21215-0036	ithin an	Completed	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT use retired)			Dod	Cros	0
7	Hygier ther ti		17. Father's Name (First, Middle,	5+		AC	countant	18. Mothe	er's Name (First, Middle, N			5
Maryland	d be f	To Be	Henry Evans,							Edwards			
ary	shoul ind Mari umati	F	19a. Informant's Name/Relations		19	b. Maili	ng Address (Street a	and Numb	er or Rurai	Route Number,	City or Town	, State, Zij	p Code)
Ž	and 2 salth a n 27 le er tre		Casandra R. Sin	gleton, Ex	-Wife 1	1 A	rch Place	Apt.	46				
ore	of He		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Removal from	State cemete	ary, cre	sition (Name of matory or other place	· 1	Da		20c. Location		
Baltimore,	Pag tment tent:		`4 ☐ Donation 5 ☐ Other (S	ipecify)	Metro		ematory I						Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event. The Medical Examiner must be notified at ORE.		21. Signature of Funeral Service Thomas Grego	or			Cremation 299 Frede:	rick	Road	Baltimo	ore, Ma	nc. ryla	nd 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that of only one cause on e	each line.						est,		Approximate Interval Between Onset and Death
<u>.</u>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cere	U lord	مع	culor	acc	iden	ct.			
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequence		were		10-1				
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,								
8760,	icate be executed physicien and s the burial-transit	ai Ex	resulting in death) Last	Due to	(or as a consequence	or):							
687	physics the I	dica		d									
Box (The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregnancy birth 2 Fetal deat	- a	75				23d. Da	ate of deliv	very
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death		□Ectopic pregnancy □ Other <i>(specify)</i>				M	onth	Day Year
P. 0.	that the de ed by the a detached f	Phy	9 Unknown Part II. Other significant conditi			in the I	andorhuna onuco anu	on in Part I		23a Did toh	acco use con	tribute to	the cause of death?
ds,	signed be del	d by	Part II. Other significant conditi	ons contributing to u	eath but not resulting	111 (119 (inderlying cause give	31) III F &I (I		1 🗆 Ye	_,		bably 4 Unknown
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Re	The lay	Jmp			<u> </u>					autops: perform	y ned?	prior to co death? 1 \sum Yes	ompletion of cause of
ta		Be Co	25. Was case referred to medica	1				26. Place	e of Death (1 ☐ Yes 2 Check only on	9)	1 1 1 1 1 1 1 1	20140
<u> </u>	A S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 ER/O	utpatie	nt 3 DOA Othe	er: 4 □ Nu	ursing Home	e 5 🗆 Reside	nce 6 🗆 Ot	her (Speci	ify)
n of	Attending Physicien: ir death. sector: After this certific by the funeral director,		27. Manner of Death 1 ☐ Matural 5 ☐ Pendir	28a. Date (Mon	of Injury 28b. th, Day Year)	Time of	Work	ς?		d. Describe ho	w injury occu	rred	
isio	death death ctor; /	icati	2 Accident investi	not be 280 Place	of Injury - At home, i	arm et		Yes 2		Rf Location (St	reet and Num	her or Ru	ral Route Number,
Division	or Attendation after death	Certification:	4 Homicide determ	nined 200. Place buildi	ing, etc. (Specify)	ami, st	reet, factory, office			City or Town		50 01 1101	
	To the Moepitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		Examiner: On the b	best of my knowledgasis of examination a								
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. License	e number			9d. Date sign	-	
	<		tept	100	, and		D59	851	0		05/0	8/0	8
1	(e 6		30. Name and address of person	on Dle	se of death (Item 23a)	(Туре	Print)						
	Sta Registr		31. Date filed (Month, Day, Year,	2008	legistrar's Signature	A	arti						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** vannie /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner WSING HOME 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 □ K Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventinal must be neithed at 2000e. 1 ☐ Kes 2 ☐ No Funeral Director MD timore 10g. Citizen of What Country? 10e Street and Number 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 **3**0 Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. econdary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. F Pages 1 and 2 20a. Method of Disposition . 1 Murial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses ~101363 49852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of existing shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheros clarotic 20 grt Physician Cardio vascular /Medical Due to (or as a consequence of): Examiner Cerebrovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Tost be executed burial-transit Diobetes mellitus Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No 5 ☐ Other (specify) P.O. ed by the a 9 DUnknown 9 Unknown signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1∐Yes 2⊡No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ms

State Registrar

mien-Door 31. Date filed (Month, Day, Year) MAY 1 3 2008

mar-p

Ron 206 32. Registrar's Signature

30. Name and address of person who complifed cause of death (Item 23a) (Type, Print)

Kiriene

821

Baltimore

Curtain street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		1	For State	State of Mar	-	Depaπment of Certificate of			reg. N		** 1 200 pm A 1
			Registrar 1. Decedent's Name (First, Middle, Last)				Dout	2. Date of	Death	£ U U 1	3. Time of Death
Physic /Med			ROBERT	EDW,	4RD	5		april	28	2008	2:55 A M
Exam			Ia. Facility Name (If not institution, give s BON SECOK	treet and number)	1.701	4b. City, Town,			4	ic. County of Dea N/A	th
Funera	20	- 4			In yrs. last bir	thday) If Under 1 Yea	r If Unde	1 0 R E r 24 Hrs. 8. Date of Min. 3-19	Birth		thplace (State or Foreign
Directo			220-04-3027	M 2□F	52	Yrs. Months Days	Hours	Min. 3-19	1950	6 MA	RYLAND
land bw			Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	n or Location					10d. Inside City Limits
Mary a-f shu ified a	1	5	MD. N/A		BALT	TIMORE					1 Yes 2 No
vith the	1	5	10e. Street and Number 1217 W. FAYETTE S	·m·		10f. Zip Code 212			10g. (Citizen of What Co USA	ountry?
leath v ns 23a must	1	2		12. Was Decedent Ev	er in U.S.	1		origin? (Specify Yes or an, Puerto Rican, etc.)	No-	14. Race - Ame	
Fe, INISTYISITIO Z IZ 13-0030 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Ithe 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	3	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No				Black, Whi	te, etc. LACK
72 ho 72 ho "natur		Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a.	Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	upation e during mo	ost of working	16b.	Kind of Business	/Industry
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na e filed al Hyg			17. Father's Name (First, Middle, Last)	NC.				her's Name (First, Mid HELMA PATE	dle, Maio	len Surname)	
yid sould b i Ment narked		10 De	RICHARD N. EDWARI		10h	. Mailing Address (Stree			ımher Cit	hy or Town State	Zin Code)
Mal nd 2 st lith and 27 is n			19a. Informant's Name/Relationship (Ty) JAMES EDWARDS (BRO	· -							MARYLAND 2123
es 1 ar of Hea fitem 2		-	20a. Method of Disposition			f Disposition (Name of ry, crematory or other p		Date		Location - City o	
0 0			1 ☐ Burial 2 ⚠ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			CREMATORY		5-2-2008			MARYLAND
permit. Par Departmen Important: any injury	ouce.		21. Signature Formal Serv. Licens	MAHTANOE	D. HIBN	NE R ^{22. Name and Add}					ME, P.A. YLAND 21217
		+	23a. Pa 1. Enter the disease, or comples oc, or heart failure. List only or	ications that caused t	he death. Do	not enter the mode of d	ying, such a	as cardiac or respirato	ry arrest,	OKE, FIAK	Approximate Interval Between
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MVISION OF Morattending Phy after death. Director: After this d in by the funeral d		Certification:	3 Suicide 6 Could not be determined	28e. Place of injurbuilding, etc.	ry - At home, fa (Specify)	arm, street, factory, offic	ce		on (Stree r Town, S		Rural Route Number,
DIVISION OF VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I		Medical C	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best o iner: On the basis of and manner stat	examination a	e, death occurred at the nd/or investigation, in m	e time, date ny opinion, d	and place, and due to death occurred at the	the caus ime, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
To th withir To th		Me	29b. Signature and title of certifier	Q			ense numbe			Date signed (Mo	
			Nosita K.	Crnz) DO	0303	. 77		pris 2	8,2008
- 1			30. Name and address of person who c	RUZ	M- D	(Type, Print)	N S	ECOURS	Ho	SPITAL	8,2008
Regi	Stat istra		31. Date filed (Month, Day, Year) MAY 1 3 200	462	r's Signature	Sperter					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:20A M FISHER MAY 09 2008 **长ENT。** /Medical 4c. Coupty of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1**Z**M 2□F Hours 214-88-5 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 35181 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: 3100 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ingrade 17. Father's Name (First, Middle, Last) Middle, Maiden Sumame) Be 8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltime MS 21244 permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other traof Health a KON/Motha Eizabeth 20b. Place of Disposition (Name of cametery, crematory or other p Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses laufun Approximate Interval Between Onset and Death 23a. Part1. Inter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardinc or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY. /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed attending physician and for use as the burial-transit DISEASE STAGE Due to (or as a consequence of) DEFICIENCY YIRUS IMMUNO Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) o 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, TUC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown MELLI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No ANEMIA 1 ☐ Yes of Vital To the Hospital or Attending Physicien: within 24 hours atter death.

To the Funerel Director: Atter this certific completely filled in by the funeral director. 26. Place of Death (Check only one. 25. Was case referred to medical examiner? Other: Hospital: 1 Tes 2D/No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 D 23300 09 MD MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECUNRS reast. SUDKIR. PATEL BALTO, ST. BALTO, MAD. 2000 W. 31. Date filed (Month, Day, Year) MAY 1 3 2008 32/Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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5/7/08 10/35am Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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G		Registrar 1. Decedent's Name (First, Middle, Las.	")		007	tmodic or	Douin	2. Date of I			3. Time of Death
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Funeral				(In yrs. last bi		If Under 1 Year Months Days		8. Date of 1	Birth Day, Year	9. Bir	thplace (State or Foreign ounty) Virginia
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yland		10a. State 10b. County		10c. City, Tov		cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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with the	Funerai Director	10e. Street and Number 813 208th Street	-			10f. Zip Code 2112	22		_	S.A.	Sommy.
death	nera	11. Marital Status	12. Was Decedent I Agned Forces?	Ever in U.S.	13. \	Mas Decedent of H f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or to Rican, etc.)	No-	14. Race - Ame Black, Whi	
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To th Within To th comp	Me	29b. Signature and title of certifier	1			29c. Licer	ise number		29d. [Date signed (Mo	nth, Day, Year)
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75		30. Name and address of person who	Ole Ru	THE C	165	o Sen.	happ 1	ld s	sul	te 110	ND ZIOUS
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Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001

completely

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Year)

ORIGINAL

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Worthern Woods

29d. Date signed (Month, Day, Year)

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** M Gallasher 5 2 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UMMC Baltimore if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Tune) 45 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Director 215-34-5823 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits irai", or items 23a or 28a-f show Examiner must be notified at Pasadena Anne Arundel Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 USA Funeral 409 Dutchship Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No þ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Westinghouse is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Ζ. Goode Edith Ī. Packman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 373 North Shore Rd., Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Russell Kirk (son) Date 13 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mount</u>ain Road, Pasadena, MD 21122 23a. Pall 1. Enter the dise e, o complications that call adhi-shock, or heart failure. List only one cause on each line Teath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** horacic Aortic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially llst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician ar for use as the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Be 2

s certificate has be lirector, page 2 s Fo the Hospital or Attending Physician; within 24 hours a To the Funeral I completely

						1 Yes 2 No	deatn? 1 ☐ Yes 2 ☑ No			
25.	Was case referre examiner?	ed to medical	26. Place of Death (Check only one)							
	Yes 20100		Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27.	Manner of Death 1 □ Natural 2 □ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, street, factorify)	ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,			
20	a Certifier 1	Certifying Ph	veician: To the heet of my kn	owledge death occurr	ed at the time, date and place	and due to the sause(s)	and manner se stated			

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

01-00 A M

1 ☐ Yes 2/☐ No

Approximate Interval Between Onset and Death

Day

2.08

Year

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 728

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Greene Baltimere UD 21201 Amin kamel

State Registrar

Certification:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** OTTIPM 2008 5 May /Medical 4c. County of Death stitution, give street and numb 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months Days 1 M 2 KF Director Hand Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d, Inside City Limits 28a-f show the Medical Examiner must be notified at 1₽Yes 2□No Director Itimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or USA Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 'natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) than * College (1-4or 5+) Health and Mental Hygiene. Is marked other 18. Mother's Name (First, Middle, Maiden Surname, Be 19b. Mailing Address (Street and Numb permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trae 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmonary immediate Cause (Final Adenocarcinoma **Physician** disease or condition resulting in death) 1 month /Medical Due to (or as a consequence of) Examiner Tobacco Use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9☐Unknown 9 I Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performe certificate or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours atter uses...

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 een 5, 2008

State

DHMH 17 Rev 1/2001

Registrar

Union Memorial Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

KRUES

2. Registrar's Signature

Green

MAY 1 3 2008

Meegan

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 BETTE ANN GUYTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNION MEMORIAL HOSPITAL BALTIMORE
If Under 1 Year | If Under 24 Hrs. N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Months 1 □ M 20XF Yrs 212-48-7407 Director 12/31/1947 MARYLAND 60 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo BALTIMORE PARKVILLE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a USA
14. Race - American Indian 21234 8700 LOCH BEND DRIVE Funeral APT. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛛 No Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE COUNTY al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FIRE DEPARTMENT SECRETARY 12TH GRADE other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 Is marked EILEEN BOHN JOHN GUYTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILLERSVILLE, MD 21108 755 N. MESA DRIVE MARGARET PRICKETT/SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State permit. Pages Department of Important: If it any Injury or o 5/14/2008 COCKEYSVILLE, MD 4 Donation 5 Dother (Specify) CARDENS THE JOHNSON FUNERAL HOME, P.A. 21. Signatury of Funeral Service Li 8521 LOCH RAVEN BLVD. TOWSON, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ORONARY years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CELL CAXCONOMI nouths Examiner WETAS TATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bue to (or as a consequence of) Examiner ng physician and as the burial-transit executed Due to (or as a consequence of) P.O. Box 68760, death certificate be Physician/Medical attending IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Por 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; perform 2 No 2 No certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA P After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury Division 5 ☐ Pending within 24 hours after com...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

3

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 3 2008

NEHAL

30. Name ress of reson who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State of Maryland / Department of He For State Registrar Certificate of D			gierie Reg. No.						
1		_	Decedent's Name (First, Middle, Last)		2. Date of Dea		2 Q 0 (3. Time of Death				
	Physicia /Medic		LELAH CATHERINE GROFT			2008		5:22 P M				
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L				Inty of Death					
-			CARROLL HOSPICE DOVE HOUSE WESTMINST 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign				
	Funeral Director		212–32–4765 1□ M 2XF 73 Yrs. Months Days	Hours Min.	(Month, Da 10/4/1		PENN	SYLVANIA				
	D ₀		Usual Residence of Decedent					10d. Inside City Limits				
	arylar show	۲	Total Ordinal Total Ordina Ordinal Total Ordinal Total Ordina Ordinal Total Ordina Ordina Ordina Ordina Ordina Ord					1√2 Yes 2 No				
	the M	Director	MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code			10g. Citizen	of What Cou	ntry?				
	death with the Maryland rms 23a or 28a-f show r must be notified at		225 FROCK DR., APT. 102 2115	57		USA						
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,					
ð	filed within 72 hours after death with the Marylar thygiene the "ratural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No			_	ecify: WHI	TTE				
5-003b	hours tural" al Ex		15. Decedent's Education 16a. Decedent's Usual Occupation	ition		16b. Kind	of Business/In					
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7	ed with	E O	12 SUPERV				FACTUI	RING				
2	be file	Be	17. Father's Name (First, Middle, Last) ALLEN EDWARD BECKER	18. Mother's Nam HELE	e (First, Middle, SN MARG		•	ER				
<u> </u>	d 2 should th and Mer 7 Is marke traumatic	٩	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street a.									
<u>8</u>	nd 2 s Ilth an 27 Is r r traur		BONNIE SUE PETRY -DAUGHTER 115 S. MAIN									
e,	ss 1 and of Healt item 2 rother		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place		Date 3 / O.S	20c. Locat	ion - City or T	own, State				
Ē	Page ment o ant: If ury or		1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SQUTH CARROLL CREMATORY WINFIELD, MD									
Baltimore,	permit. Departimporti		21. Signature of Funanti Service Licensee 22. Name and Address					OME, P.A. D 21157				
ř	5 1		23a. Pan1. Ener the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	g, such as cardiac	or respiratory a	rrest,	·	Approximate Interval Between				
	Physician	i n	Immediate Cause (Final disease or condition CHZOUCOBSTUCTIVE POLMOLARY OVERS 546									
	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
E	\$16.7	er	Sequentially list conditions b. Due to (or as a consequence of):									
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5	ficate be executed griphysician and ts the burial-transit	Exe	resulting in death) Last Due to (or as a consequence of):									
68760	cate b ohysic the bi	edical	d									
_	± 5 5	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			230	I. Date of deli	very				
Box	death certi e attending ed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in ☐ Yes 2 ☑ No ☐ Unknown				Month	Day Year				
0	at the by the tache	hys	9 ☐ Unknown	00. Did	23e. Did tobacco use contribute to the cause of death?							
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Vital Records,	w require been sij should t	Completed			24a. Was	an :	24b. Were au	topsy findings available completion of cause of				
Re	The fa te has age 2	dmo			auto perf 1⊟ Yes	orma¢i? 2 X No	prior to death? 1 ☐ Yes					
ta		Be C	25. Was case referred to medical examiner?	26. Place of Dea								
	or Attending Physician: The tailufter death. Director: After this certificate has in by the funeral director, page 2	1 Yes 25 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 20 Other (Spe										
S L	ing l	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 1 Accident investigation 1 Accident investigation	yat ⟨? Yes 2□No	28a. Describe	now injury c	ccurred					
Division or	il or Attend after death I Director: , d in by the f	ficat	2 Accident 3 Suicide 6 Columnia 6 Categorium 28e. Place of injury - At home, farm, street, factory, office		eet and Number or Rural Route Number,							
2	s after al Dire	Certification:	4 Homicide determined building, etc. (Specify) City or Town, State)									
	To the Hospital of within 24 hours af To the Funeral D completely filled it	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)				
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License	- 4		í	signed (Montl					
			Thomas K. Golus II m D	31660		5/1	7/500,	원 				
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	100 A	Pak if			e. n				
	V (31. Date filed (Month, Day, Year) 32 Registrar's Signature	NEZ AU	crane (V 6211	ハノング	in mountain				
	St: Reaist		MAY 1 3 2008									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item 1 per dr., g879,05/23/08dbb	ientai Hyt	giene Reg. No.						
16,0	Physici /Medi		1. Decedent's Name (First, Middle, Last) Frank A. Gottleib, Jr.	2. Date of Dea Month May	Day Year						
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Modicul Center Glen Bull	1,e	Anne A	rundej					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 212 - 43 - 1962 120 M 2 F 52 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day	n 9 Bi	rthplace (State or Foreign country) aryland					
036	Maryland a-f show iffed at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pasadena			10d. Inside City Limits 1 ☐ Yes 2 ☑ No					
	ith with the 23a or 28 ust be not		10e. Street and Number 262 4th Street 21122		10g. Citizen of What C USA	ountry?					
	be filed within 72 hours after death with the Maryland ntal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.					
15-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of worki	ing	16b. Kind of Business	s/Industry					
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and	id be f ental } ked ot ic ever			interli	,						
Maryland	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura	al Route Numbe	er, City or Town, State,	Zip Code)					
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Baltimore,	Pages nent of int: if if		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	/08	Elkridge,	Md.					
Ba	permit. Departri Importa any inju		Gon	ce Fune	ral Servic	e P.A.					
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventuciar Tachycardia I hour								
	Examiner	je.	Due to (or as a consequence of): Sequentially list conditions. b. Hywardi al Infarction			2 weeks					
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	sertifica ding ph se as th		IF FEMALE:								
Records, P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year							
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	sician: The law r certificate has be rector, page 2 sh			24a. Was a autop perfor 1□ Yes	med? death?	utopsy findings available completion of cause of s					
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Types 20 No Hospital: 1 Dispatient 2 No Felicuttrations 3 Doca Other: 4 Dispatient 4 Doca Other: 4 Do								
Division or	ding Phys h. After this funeral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
Sior	Attendir death. ctor: Af y the fur	catio	2 Accident investigation M 1 Yes 2 No								
<u>></u>	itai or Al	Certification:	4 Homicide determined 286. Place of Injury - At nome, tarm, street, factory, office building, etc. (Specify)	City or Tow							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a complex of my knowledge, death occurred at the time, date and place, a complex one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ded at the time, of	cause(s) and manner a date and place, and du	s stated. e to the cause(s)					
	With To 1	Σ	29b. Signature and title of certifier 29c. License number D-36885		29d. Date signed (Mon	th, Day, Year)					
•	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Careene St. Baltimore, MD 21201								
	Sta		31. Date filed (Month, Day, Year) 32 egistrar's Signature	/							
	Registr	ar	MAY 1 3 2008 Breve B parti								

FRANK GOTTLEID

For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2008 NORMAN GURWITZ MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) 11/23/1921 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 217-16-3044 86 MD Director Usual Residence of Decedent the Marviand 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show 1 ☐ Yes 2 No Funeral Director MD BALTIMORE **PIKESVILLE** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with to and Mental Hygiene.

is marked other than "natural", or items 23a or? 4204 OLD MILFORD MILL ROAD 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. was Decedent Ever in U.S. Armed Forces?
1 ∑IYes 2 □ No ARMY If Yes, Give Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1 □Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN WHOLESALE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY GURWITZ KATE FISHER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an Health a tem 27 is ALAN GURWITZ / SON FARMHOUSE COURT. PIKESVILLE, MD 20b. Place of Disposition (Name of cemetry, 14 CT ON other place)
CHIZUK AMUNO CONG. 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 05/12/2008 BALTIMORE, MD 21. Signature of Funeral Service Licerses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Do not enter the mode of dying such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Directo for as a consucuence of: pital or Attending Physician: The law requires that the death certificate be executed ours after death.

earal Director: After this certificate has been signed by the attending physician and illied in by the Internal director, page 2 should be detached for use as the burnal-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant condition ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1838 Greene Tree 32. Registra ^{Year)} 2008 State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 9879 5-13-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SDay Year **Physician** ANNE MAY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDAISTONN BAL TimbrE CENTER MORTHWEST If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 TF 64 02-09-1944 Director 249-72-5714 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director WILMINGTON DE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 19802 3008 N. MADISON USA Funeral death 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK ۾ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HEALTH CARE REPRESENTATIVE** NURSING Department of Health and Mental Hygie Important: If them 27 is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be PAUL GENERETTE DESER LEE DOCTOR ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4700 DUNCANNON RD., PIKESVILLE, MD 21208 NATHASA WERTS/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CYPRESS CREEK CH.CEM 05/17/2008 WALTERBORO, SC 21, Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H, INC ames (1701 LAURENS ST., BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEMONRITHGIC CENEBROVAS CONLAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical as attending properties of the second 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9□Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ · Acute RESPINATERY TASLURE: 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SHUCK SEPSIS! SEPTICE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. VALUE REPLACEMENTED 24a. Was an · METHICITION RESISTANT Auntus Brotenomi Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 v ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ON(ANDO

31. Date filed (Month, Day, Year)

NONTHWEST HOSPITAL CENTER

many LAND

RANDALLE WIN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

B. CONANAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:44 PM **Physician** STANLEY Ε. HOCH JR. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Tacoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex, 1 M M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Yrs. 216-36-8163 67 Director 25, 1940 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or flems 23a or 28a-1 show any injury or other traumatic event, it is Medical Examiner mass to a second any injury or other traumatic event, it is Medical Examiner mass to a second and injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Montgomery Silver Spring. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3233 South Leisure World 20906 R1 vd. U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 I No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company 12 Insurance Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley E. Hoch ပ္ Margaret Steele 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3233 South Leisure World Blvd. Silver Spring
20906
20c. Localion - City or Town, State 19a. Informant's Name/Relationship (Type, Print) Karen B. Hoch 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crownsyille VA Cem. 1 4 ☐ Donation 5 ☐ Other (Specify) 5-12-08 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one pluse on each line. Approximate interval Between Onset and Death In rediate Cause (Final asease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-trar Division of Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 281 No 201 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 O Natural 5 Pending death. s after death. 1 ☐ Yes 2 ☐ No 2 Accident the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 T Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person person mpleted cause of death (Item 23a) (Type, Print) BRYAN M. STEINBERG mo 3001 HOSE ITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2:30 A 0 2008 0 Clare Harris Tna /Medical 4c. Qounty of Death 4a. Facility Name (If not institution, give street and number) Examiner Square 10sedale Hospita Himora If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 □ M 2 🔀 F Days North Carolina 1929 Director 220-20-3584 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show injury or other traumatic event, the Medical Exarctions rust by rutified at 1 □Yes 2X No Director Dundalk MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 101 Center Place, Apt. 902 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or items 11, Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Harris Tng Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: <u>۾</u> Specify: **Black** 3 XWidowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "y any injury or other traumatic event, it is increase. Elementary/Secondary (0-12) College (1-4or 5+) **Hospital** 12 Nurses Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara McCoy Fred Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 609 Kingston Road, Middle River, MD Valerie Mabry - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/13/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner be ia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 9 attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

Physic /Med Exam

Funera Directo

Physician /Medica Examine

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

_ For	State of M	/laryland /	Depar	rtment of H	eailii ailu i	wientai i iy	gierie		
1 - State Registrar			Cert	tificate of D	Death	7	Reg. No	008	15538
1. Decedent's Name (First, Middle	, ,					2. Date of De Month	Day	Year	3. Time of Death
Wilbur H.								8008	5:48 A N
4a. Facility Name (If not institution		,	'	4b. City, Town, or		n		unty of Deat	
Greater Baltim 5. Social Security Number		Center	irthday)	Towson	n If Under 24 Hrs.	8. Date of Bir	Bal	timor	e thplace <i>(State or Foreig</i>
215-05-3101	№ м 2□ F	90		Months Days	Hours Min.	8. Date of Bir (Month, Da April 2	7.191	8 Mar	vIand
Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	wn or Loca	ation			7		10d. Inside City Limits
,	imore								1 □Yes 2 X No
Maryland Balt	imore		Towso	10f. Zip Code			10a Citizer	of What Co	
7001 N. Charles	Street			21.20)/ı		_	USA	and y.
11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Wa	as Decedent of His		pecify Yes or No			rican Indian.
1 ☐ Never Married 2 ☐ Mar	Armed Forces ed 1 ☐ Yes 2 2	?	If Y	Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)		Black, White	e, etc.
3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates	:	11	□Yes 2XNo	Specify:		Sp	ecify: W	hite
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Elementary/Secondary (0-12)	College (1-4or		life. DC	O NOT use retired)	-		۸	tomoti	170
17. Father's Name (First, Middle,	Last)		Sales		18. Mother's Nan	ne (First Middle			.ve
Herbert C. Hut	,					na Hopki		namej	
19a. Informant's Name/Relations		10	h Mailine	Address (Street a				Num State	Zin Cade)
Thomas H. Huts		i	-	Tufton Ri			-		•
20a. Method of Disposition	5011	20b. Place of	of Disposit		uge Road	Date		ion - City or	
1 ☐ Burial 2 📈 Cremation	_			HIUH (Wallie Ut		Date			
		9	ery, cřema	atory or other place	´ ¦ .			•	M1 1
4 □ Donation 5 □ Other (S	pecify)	9	ery, crema Cren	atory or other place natory In	nc. 05/1	12/08	Balt		Maryland
4 Donation 5 Other (S 21. Signature of Funeral Service Thomas Grego 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	gcensee	Metro	Crema Crem Cr 201	matory or other place matory In Name and Address remation 99 Freder	nc. 05/1 Society rick Road	12/08 Of Mary d Baltim	Baltand,	Inc.	*
4 Donation 5 Other (S 21. Signature of Funeral Service Thomas Grego 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cause only one cause on each a	Metro	Crema Crema Crema 22 Cr 25 D not enter	matory or other place matory In Name and Address remation 99 Freder	nc. 05/1 Society rick Road	12/08 Of Mary d Baltim	Baltand,	Inc.	and 21228 Approximate Interval Between
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State Registrar Tomon MD 2/204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Charles

RCAN-CARDEN

31. Date filed (Month, Day, Year)

MAY 1 3 2008

DHMH 17 Rev 1/2001

Registrar

MAY 1 3 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 6:04 ам Walter Hawkins May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral №** M 2□ F Months Days Hours Min. 89 Director 225-16-0532 Usual Residence of D 1-21-1919 VA Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examilmen must be mortified at 1 ☐ Yes 2 ☐ No Brunswick Director 10e. Street and Number White Plains 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 466 Bright Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Specify: African-American 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) J.W. Moody Logging Co. Limberman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Harrison Lundy Hawkins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4650 Alcott Way, Owings Mills, MD 21117 Nadine Hawkins/ Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Broadnax, VA Harrison Family Cemetery 114 108 05 4 Donation 5 Other (Specify) ure of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Menths disease or condition resulting in death) 1 V2 CI /Medical Due to (o as a consequenc; of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Plantin 24 hours after death.

To the Funeral Director. After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 25205 Name and address of person who completed cause of death (Item 23a) (Type, Print). Charles St. Balts. and Z120x 5 6-BMC 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Spark Registrar

DHMH 17 Rev 1/2001

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	Physicia /Medic	al .		STEWART H		MAY 10,	2008	7:00 A ^M
)	Examin	er	4a. Facility Name (If not institution, give street and number) CARROLL HOSPITAL CENT	ED.	4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign try)
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	/land ow at		10a. State 10b. County	10c. City, Town or Loc	cation		1	0d. Inside City Limits
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326	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Medical Examiner must be notified at	by	Armed Forces? 1 Never Married	10	f Yes, specify Cuban, Mexican, Puèrto l □ Yes 2 X No <i>Specify:</i>	Rićan, etc.)	Black, White,	
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Maryland 2	2 she and Is ma		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Number or Run			,
	s 1 and f Health item 27 other tr		KATHY ANN HAINES - WIF		W. BALTIMORE S sition (Name of natory or other place)		Location - City or To	
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DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to make the funeral director, to the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injubuilding, etc.	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Street City or Town, S.	t and Number or Rura tate)	l Route Number,
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	To t Withi	N	29b. Signature and title of certifier	1	29c. License number	29d.	Date signed (Month,	Day, Year)
	10		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print) (\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	11	1.00	021107
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 7:30 PM M 2008 May 4, Charles A. Herbert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson 8. Date of Birth (Month, Day, June 27, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Ĩ933 74 Director 213-30-1094 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21234 USA 1390 Deanwood Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Calvert Distillery machinest h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Ruth Elizabeth Brooks John Adam Herbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trainonce. 1390 Deanwood Road Baltimore, MD 21234 Erna Herbert/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) permit. S. Wade Ronal C 21. Signatur State Anatomy Board 655 W. Baltimore Street Director m 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Baltimore, MD Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

Due to (or as as Physician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Vear 5 ☐ Other (specify) To the Hospital or Attending Physician: The law requires that the ue within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by des esse 1 🗆 Yes 2 🗆 No 3 Probably 4 Unknown 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? edse 2 No 1 TYes 0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA aca 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier I 🗗 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

MAY 5, 2005 29b. Signature and title of ertifier 29c. License number 25205 de Charles St. Balto and 2:208 and address of person who completed cause of death (Item 23a) (Type, Print) 01 & MC 6701 32 Registrar's Signature 31. Date filed (Month, E

State Registrar Y 1 3

2008

DHMH 17 Rev 1/2001

ORIGINAL

		•	1 - State amend #1 I	State of Ma Per Phy G87	ryland / l 79 5/12	Departme 198 rtilica	ent of F	lealth and M Death	fental Hy	giene 200	8 15543
	Physicia	an	Decedent's Name (First, Middle, La.			John A.			2. Date of De Month	ath 5-11-20	3. Time of Death
5	/Medic Examin		4a. Fecility Name (If not institution, give	a street and number)		4b. C	ity, Town, o	r Location of Death		4c. County of D	
	LAdiniii	e.	6390 Beechfield A			E	lkridg	ge		Howard	
	Funeral Director		5. Social Security Number 6. S 218-32-4405	ex 7. Age XM 2□F	95	Yrs. If Un Monti	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De April	th by Year) 8,1913	Birthplece (State or Foreign Country) MD
	p.		Usual Residence of Decedent		10a City Tour	or Location					10d. Inside City Limits
	Marylar f ehow	tor	MD 10a. State 10b. County Howard	100	10c. City, Tow Elkrid						1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of Wha	t Country?
	th with	alD	6390 Beechfield	Avenue		2	21075			U.S.A.	
5-0036	be filed within 72 hours after death with the Maryland Hygiene. did thygiene. do that than "natural", or itema 23e or 28e-f ehow event, the Miccinal Examiner must be mortified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	Ever in U.S.	If Yes, s	cedent of H specify Cuba 2 X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indian, Vhite, etc. White
7	within 72 ho ene. than *natur ne Medical	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed) College (1-4or 5		a. Decedent's U (Give kind of life. DO NO	work done	during most of work	ing	16b. Kind of Busin	ess/Industry
2	filed wi Hygien thar th	Co	6		Mo	echanic		10 14-15-1-1-1	- /Fi A 41-d-46-	Automot	ive
aryland		Be c	17. Father's Name (First, Middle, Last) John Herbert					Sarah	e (First, Middle	, Meiden Surname)	
<u> </u>	should be nd Menta marked imatic ev	<u>1</u>	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Addr	ess (Street		al Route Numb	er, City or Town, Sta	te, Zip Code)
Σ	od 2 lith a 27 is r trav		Ms. Geraldine Cam		1					dge, MD 2	
altimore,	Pages 1 and 2 nent of Health int: If Item 27 iry or other tru		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specification)		20b. Place o	of Disposition (ery, crematory (athedra	Name of or other place	(e) May	Date	20c. Location - City Baltimor	y or Town, State
Balti	permit. Pages Department of Important: If it any injury or o	Ī	21. Signature of Funeral Service Licer	1	10135					Funeral δ	Cremation Le, MD 21061
			23a. Pert1. Enter the disease, or com shock, or neart failure. List only	plications that caused one cause on each lir	the death. Do	not enter the r	node of dyir	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Con	aestiv	e co	rdio	24000	thy		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	nsequence	of):		tension	8		
П		er	S quentially list conditions	b. Due to (or as	a consequence	A H	4000	+672.02			1 year
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events		20	ч	, r				20 years
oʻ	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as	a consequence	e of):					
68760,	ate be hysicii he bu	edical		_ d							1
		Med	IF FEMALE:	22- 14	-4						
P.O. Box	The law requires that the death certif tle has been signed by the attending age 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat	h 3⊟Ectopi 5⊟ Other	c pregnancy (specify)	/		23d. Date of Month	delivery Day Year
	quires that n signed by	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the underlying	ig cause giv	en in Part I.		7.4	te to the cause of death? Probably 4 □Unknown
Division of Vital Records,	The law requiresate has been single 2 should to	Completed				-			24a. Was auto perfe 1 Yes	psy prior	e autopsy findings available to completion of cause of th? Yes 2□ No
ta		BeC	25. Was case referred to medical				Liber 9	26. Place of Deat			163 20110
>	Physician: this certifica al director, p	ToE	examiner? 1 ☐ Yes 2 No	Hospital:	nt 2□ER/O	outpatient 3	DDA Oth	er: 4 🗆 Nursing Ho	ome 5 Resi	idence 6 🗆 Other (Specify)
onoi	ding F h. After funer		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injur (Month, Day	y Yeer) 28b.	Time of Injury M	28c. Injur Wor 1 🗀	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
Divis	al or Attan s after deat il Director: sd in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc		farm, street, fac	tory, office		28f. Location (City or To	(Street and Number o wn, State)	or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death occur ind/or investiga	red at the tir tion, in my d	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and manne , date and place, and	er as stated. due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	~.			29c. Licens	e number		29d. Date signed (A	Month, Day, Year)
	1		30. Name and address of person who		eath (Item 23a)) (Type, Print)	U .,			211	
1	4 '		2850 N Red				m	0			
U	Sta Reg istr		31. Date filed (Month, Day, Year)	008 32 Tegistra	ar's Signature	Grand	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8 10g per fh 9879 5-13-08 vt State of Maryland / Department of Health and Mental Hygiene For Figure Amend 10e, perFH, g879 5/23/08 TT Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician ucille H0001 18 19 2000 /Medical Mar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yeal 931 Birthplace (State or Foreign Country) **Funeral** Days Yrs Director 246 48 3524 76 OCT.14,1932 N.C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Director MD N/A BALTIMORE 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 1837-8-37 N . 10f. Zip-Code 23a or 21 CHESTER ST. by Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **№** No Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mea Elementary/Secondary (0-12) College (1-4 or 5+) 12TH <u>HOMEMAKER</u> HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH HOOD ည ROCHELLE MC CLEAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA CHEEKS ARTIS (daughter) Baltimore, 2601 Perring Manor Rd. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GARDENS OF FAITH MAY 14,2008 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B.SCRUGGS FUNERAL HOME Unader 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Due to (or as a co sequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter tracifying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Tetal death 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page is certificate h I director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient မ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident (Month, Day within 24 hours after death.

To the Funeral Director: A completely filled in by the f death. М 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 02 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) orrel E. Brown 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 egistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2:38 PM Edward Hyland /Medical Harry 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ranklin Square Baltimore Rosedale Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In) **Funeral** 5. Social Security Number 216-10-7907 Days 1 🔀 M 2 🗆 F Julv12.1917 Marvland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ust be notified at 1 ☐ Yes 2 No Director Md. Baltimore Eastwood 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 23a or 21224 U.S.A. East Baltimore Street 7147 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Experiment once. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1√ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. White Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Allied Chemical Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Presser Hyland 2 Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101419a. Informant's Name/Relationship (Type. Print) Barbara A. Hyland/Daughter | 1001 Running Creek Way Unit C Bel Air, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Donation 5 Dother (SpeckIntombment Sacred Heart of Jesus May14,2008 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA trabot 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or Examiner ~ der Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a bonseouance of: Examiner law requires that the death certificate be executed burial-transi the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by t 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760. P.O. Division of Vital Records,

After this funeral c To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

10+1

Sebastian K. John, M.D. 3023 Eastern Ave. Baltimore, Md. 21224 State

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature as

3 Suicide

29a. Certifier

Medical

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 Could not be determined

title of certifier

MAY 13



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

EBASTIAN JOHN

1 ☐ Yes 2 ☐ No

0005517

🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAYth 7, 2008 8:15p м **Physician** MAXINE R. HOPKINS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner ESSEX** BALTIMORE 1421 SUSSEX RD. f Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 2 TF NORTH CAROLINA 219-22-3935 Usual Residence of Decedent 5-1-1930 78 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □ No Director MD. BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1421 SUSSEX RD. 21221 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be COLUMBUS McINTYRE CHRISTINA IVORY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Physician /Medical

permit. Pages 1
Department of H
Important: If itel
any Injury or ott

WANDA VALENTINE (DAUGHTER)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7001

egistrar's Signature

WASBEM

2008

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
nn: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other tranualite event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be executed

Medical Certification: To Be Completed by Physician/Medical Examiner and attending physician for use as the buria signed by the at d be detached for has within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician;

	ENTOMBMENT HOI				SSEX, MAR	
21. Signature of Funeral Service Lice	isee JONATHAN D.	HIBNER Name	and Address of Facility	PHILLIPS FUN	IERAL HOM	E, P.A.
Jaath	U. AlBu	1721 سا	-27 N. MONROI	E ST. BALTIN	ORE, MAR	YLAND 21217
23a. Part1. Inter the disease, or com shack or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not enter the n	node of dying, such as card	iac or respiratory arrest,	10.	Approximate Interval Between
Immediate Cause (Final disease in condition resulting in death)	a Colon Co	ancer.	with Lung	and Bran	n .	3-3/2 40
resulting in death)	Due to (or as a consec	uence of):		meris	lan,	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a conseq	juence of).				
that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of	contributing to death but not res		g cause given in Part I.		o use contribute to 2 ☐ No 3 ☐ Pr	the cause of death?
				24a. Was an autopsy performed' 1 Yes 2 1	? death?	utopsy findings available completion of cause of
25. Was case referred to medical			26. Place of D	eath (Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 DResidence	6 □Other (Spe	cify)
27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, fac fy)	ttory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ıral Route Number,
	nysician: To the best of my knominer: On the basis of examination and manner stated.					
29b. Signature and title of certifier	W.D		29c. License number D - 38-7		Date signed (Mont	h, Day, Year) - 2008

1419 SUSSEX RD. ESSEX, MARYLAND 21221

Date

20c. Location - City or Town, State

21221

State

Registrar

MALIKA

31. Date filed (Month, Day, Year)

MAY 13

BASTERN ALVO. MD -

Examiner Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Division or Vital Records, P.O. Box 68760. certificate has this After t Hospital or Attending within 24 hours after death To the Funeral Director:

filed within 72 hours after death with the Maryland Hygiene.

When than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important; If item 27 is marked other I any Injury or other traumatic event, the

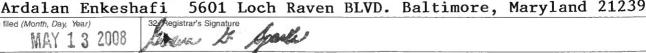
r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural
2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 3



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

215 62

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Medical xaminer Table Tab		+	23a. Part I. Enter the disease or complications that caused the death. Do not en	ter th	ne mode of d	ying, si	uch as cardi	ac or respiratory	arrest,	shock, or heart	Approximate Interval
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (or as a consequence of):	/Medical		Stab (1) and Cutting (1) Mound	s of	f Neck						
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Companies of the part of the		힐	if any, leading to immediate Due to (or as a consequence of):	_							
Companies of the part of the		amir	(Disease or injury that initiated	_							
23b. Was decedent pregnant in the past 12 months? Company Com	cuted und transit	Ĭ.									
23b. Was decedent pregnant in the past 12 months? Company Com	be exe	ğ									
A Pregnant at time of death 5 Other (Specify)	876(tificate ng phy as the b	Ž.	23b. Was decedent pregnant in the	Fe	etal death	3	Ectopic pr	egnancy			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	DX 6 ath cert	sicia	past 12 months? 4 Pregnant at time of death 5	Ot	ther (Specify	·)			İ		8
The state of the s	D. B.	품	9 Olikilowii	the t	underlying ca	ause giv	ven in Part I	. 23e. D	id tobac	cco use contribute	to the cause of death?
24a. Was an autopsy findings available prior to completion of cause of death? 1	, P.C	g P						_ 1_	Yes 2	2 ✓ No 3 Pr	obably 4 Unknown
Part of the part o	ords	ete						a	utopsy	prior to	completion of cause of
25. Was case referred to medical examiner? 1	Recont The lare cate has page 2	Ē									
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Continued (Specify) Local Street 1200 Block of James Street, Baltimore, MiD 29a. Certifier 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ivisi or Att after d Direct	tilic:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	stre	et, factory, o	ffice bu	ilding, etc.				
# 4 E a F Centifying Physician. To the best of my knowledge, death occurred at the ame, date and place, and date to the code (s) and market as the code	Ospital hours nuceral y filled	O F	29a. Certifier 4 Continue Physician To the best of my knowledge, death to	00011	rred at the tir	me dat	e and place				
Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	Fo the How within 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation	sti9a	tion, in my o	pinion,	death occur	rred at the time, o	ate and	place, and due to	the cause(s)
29b. Signature and title of centrier	5. iv 5. iv	Me							- 1		Month, Day, Year)
O.C.M.E. May 8, 2008	2		4//		(7.C.N	1.E.		N	viay 8, 2008	
OCME 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	OCME	Ī		11	1 Penn S	treet.	Baltimor	e, MD 21201			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	43	Company of Company						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Noodrow Johnson 10 200 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SINAI HUSPITAL OF BALTIMORE BALTIMORE 91 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**5**M 2□ F Months Days Hours 250.70.3702 Director 07/30 Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Madical Exominat must be notified at MD Baltimore Baltmore Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6214 21207 Norvo USA Funeral Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items : any Injury or other traumatic event, the Macital Examinar ma 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 Specify: þ 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board 2 years 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie M. Nichols Johnnio Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnson 214 Norvo Road Baltimore MD 21207 Delois Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/17/08 Woodlawn, MD 22. Name and Address of acility Vaughn C. Greene Funeral STVCS 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Road Pandallstown MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ent. Illustrations (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏞 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Medical Certification: To 1 mpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the within 2 To the I 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) D0065563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORRISON BRYANI MD SINH HOSPITAL OF RALTIMORE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 13

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 10:59 AM Jones 05 Edith 08 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Johns Hopkins
5. Social Security Number Bayriew Medical 6. Sex 7. Age Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

Wooths Days Hours Min. October 22,1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 21 F 218-36-0899 Yrs. Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heaith and Mental Hygiene.
nt: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show sdical Exaπiner must be notified at 1 ☐ Yes 2 🕱 No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 8206 Gray Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Hairdresser 12 vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Bonomo Beatrice Redman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Husband 8206 Gray Haven Road, Dundalk, Maryland William Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery May 14,2008 Dundalk,Maryland 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, shock, or heart failure. Li complications that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Due to for as a conjequence of) failure day /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Breast Canur autopsy performe 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending Physician: 0

Hospital c within 24 hours a To the Funeral I

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 13

DHMH 17 Rev 1/2001

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chy, Johns Hopkins

2008

29c. License number

RES-000

Bayin Medical Center, 4940 Eastern Ave, Baltimore, MD 21224

Registrar's Signature brasiles

29d. Date signed (Month, Day, Year)

05/08/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician MAM 45 MYER JUDD O 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A LEVINDALE HEBREW HOME 8. Date of Birth Month Day Year) 05/25/1919 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X** M 2□ F 88 169-14-4514 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 1ry or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f shor adical Examiner must be notified at 1 XYes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7111 PARK HEIGHTS AVENUE, #110 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DRUG FAIR College (1-4or 5+) Elementary/Secondary (0-12) DRUG STORES REGIONAL MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JUDD JACOBS REGINA JACOB ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 PARK HEIGHTS AVENUE, #110, BALTIMORE, MD 21215 LILLIAN JUDD / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW 05/12/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MeH 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** men /Medical Due to (or as a col equence of) Examiner ON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably has been si e 2 should l Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 10 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Maturai 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🞢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6 243 ane

DHMH 17 Rev 1/2001

。State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Year

Registrar DHMH 17 Rev 1/2001

State

6 701

31. Date filed (Month, Day, Year)

SILL TE 400),

CHARLE

Registrar's Signature

NORTH

32.

			For State Registrar	State of Marylar				ientai Hyg	jiene	
				4)	Cei	rtificate of I	Death	2. Date of Dea	leg. No.	3. Time of Death
	Physicia	_	1. Decedent's Name (First, Middle, Las	Known as La	11 Ko	11. 531 F		Month	Day Year	3. Time of Death
	/Medic	_	4a. Facility Name (If not institution, give		11/10		r Location of Death	May	5 2008 4c. County of Dear	10/5
	Examin	er	2	1	1 look	- 4	Burnie		Anne 1	
See and	Funeral		5. Social Security Number 6. So	ex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rin	thplace (State or Foreign
Н	Funeral Director			□M 2MF 82	2 Yrs.	Months Days	Hours Min.	Aug. 0		ountry) SCONSIN
	ס		Usual Residence of Decedent							
	rylan how	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	e Ma Ba-f s	5	Maryland Anne Ar	undel	P8	asadena				The state of the s
	or 28	Director	10e. Street and Number 508 Riverside Dr	rivo		10f. Zip Code	1122		10g. Citizen of What Co U.S.A.	ountry?
	ath w									
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	9.S. 13.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, Whit	
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: Wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show snt, the Medical Examiner must be notified at	edk	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	1	16b. Kind of Business	/Industry
5	in 72 n "ne Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ing		
212	i with	E	12	4	Sub	stance Ab	use Couns	elor	Johns Hopk	cins Hosp.
פַ	othe rent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname)	
<u>a</u>	ould be Mental arked o	TO E	James O'Conno	or			Eliza	beth	Hauch	
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State,	
	and 2 ealth n 27 l		John E. Krawczyk						,Maryland 2	
ore	of Her		20a. Method of Disposition 1	Hemoval from State	-1	osition (Name of matory or other plac	1	Date	20c. Location - City or	
Ĕ	Pages ment of I ant; If Ite		4 □ Donation 5 □ Other (Specify			dge Mem.	1	08-08	Elkridge, N	Maryland
Baltimore,	permit. Page Department Important; If any injury o		21. Signature of Funeral Service Licer	ISERT A	$M_{\rm M}^2$	2. Name and Addre	ess of Facility Lyniak Fu	neral H	ome P.A.	
	20 E 29		June S	Jann	13	204 Mount	ain Road.	Pasade	na, Marylar	
В	nt I		23a. Part. Enter the disease, or com	plic tions that caused the dea o cause on each line.	th. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		I mediate Cause (Final Isease or condition resulting in death)	a. Aspiration	rin	ermonia	<u> </u>			1 west
7	/Medical Examiner		resulting in death)	Due to for as a consec	quence of):					10
	\$ - P36 *	<u>_</u>	Sequentially list conditions,	b. Due to (or as a consec	Tuence of:					UNKNOW
7	tec nsir	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (0) 40 4 00 100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Z-	ficate be executed physician and is the burial-transi	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
687605	e be (sicial		(-d						
89	ificat g phy as the	edical								
Вох	leath certifi attending I I for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr 1□Live birth 2□Fet		□Ectopic pregnanc	v		23d. Date of de	•
	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-trans.	Physician/M	in the past 12 months2 1 ☐ Yes 2 ☐ Ho	4☐Pregnant at time of		Other (specify)	у		Month	Day Year
<u>Р</u> О	that the de led by the a detached f	hys	9 ☐ Unknown							
	ires that signed is	by F	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.		obacco use contribute t	
ord	w requir been si should							10	Yes 2. 1 No 3. F	Probably 4 Unknown
ec	e law has b	ple						24a. Was autor	osy prior to	utopsy findings available completion of cause of
H		Completed						1□ Yes	rmed? death? 2₽₩0 1□Ye	
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		nt 20 DOA Oth	26. Place of Dear			
or Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director,	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	III OLI DOA	4 L Nursing H		dence 6 Other (Sp.	ecify)
u C	aling I	ion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk?]Yes 2 □ No	Zou. Describe i	low injury occurred	
isic	death death ctor: / the	icat	3 Suicide 6 Could not be		ome, farm, st		7100 2010	28f. Location (S	Street and Number or F	Rural Route Number.
Division	or A after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)	,,		City or Tox	vn, State)	
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral			ysician: To the best of my kn						
	e Ho	Medical	(Check only 2 Medical Example)	niner: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occu	rred at the time,	date and place, and du	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
			Can Mari A	Lester, mo		055	915		May 8,2	700 8
•	Í		30. Name and address of person who			11	0 1 0	3 0		
_	Le			ester, mo	3011	to spital	12.61	en BVI	Me, MD	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	2000				
	Registi	ar	MANU 1 9 201	18 Falling A	To Ago					

DHMH 17 Rev 1/2001

08-03553

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rubymaria Kish State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 9, 2008 1605 hrs Medical Examiner Rubymaria Kish 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7731 Spencer Road Glen Burnie Anne Arundel **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Director Country) 352-44-4491 1 M 2 X F 58 05/22/1949 FL. Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No or 28a-f show MD Anne Arundel Glen Burnie Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7731 Spencer Road U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Armed Forces Yes Widowed Yes, Give Year Yes 2 X No specify: 4 Divorced Specify: white þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 72 College (1-4 or 5+) the Medical timore, MD 21215-0036 1 and 2 should be filed within Health and Mental Hygiene. 12 Housewife Own Home it: If item 27 is marked other other traumatic event, the Mi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Stephen Vogt Rubylee Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gerald Urban Kish / husband 7731 Spencer Road; Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, A. Pages I an partment of Hr apportant: If Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Chesapeake Cremation 05/14/2008 4 Donation 5 Other Specify: Stevensville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21 Separature of Funeral Service Licenses MW918 2nd Ave SW; Glen Burnie, MD 21061 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Death failure. List only one cause on each line. /Medical Immediate Cause (Final disease Evocrteravia atherection tic cardiovacular diseas ⊊xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - trai Physician/Medical XUNPENDED AMENDED 23a.27 The law requires that the death certificate be 23a, 27, perMe, q880, 6/25/08 TT 23c. If yes, outcome of pregnancy Box 68760. 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other₄ this Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ۵ 1 ✓ Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending within 24 hours after death. Director: d in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) To the Funeral 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. OCME May 10, 2008 Resilon 30. Name and address of person cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registra

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** STANLEY KATZEN 1903 MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/13/1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. VIM 2□F Months Days Hours 212-30-1512 76 Director MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No ns 23a or 28a-f sh must be notified Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8417 DORIAN ROAD 21208 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married o. 1 ☐ Yes 2 💢 No WHITE Specify Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ACCOUNTANT CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil Department of Health and Mental In Important: If Item 27 is marked oth any injury or other traumatic even once. Be D ဂ္ WILLIAM KATZEN BERTHA GOLDBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 TAMWORTH ROAD, BALTIMORE, MD RONALD KATZEN / SON 21210 20b. Place of Disposition (Name of cemalary of material PM) (Name of ATTZ CHAIM CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State 05/11/2008 5 Other (Specify) BALTIMORE, MD 4 Denation of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VENTRICULAR 1 WEEK TACHYARRHYTHMIA /Medical Due to (or as a consequence of): Examiner 5 YEARS ISCHEMIC CARDIOMYOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 🗌 Yes 2 □NO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 2□No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 8 2008 RES - 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEEPA RAGHAVAN SINAT HOSPITAL OF BALTIMORE Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29d per doc Department of Health and Mental Hygiene 0 8 15555

			1 - For State Registrar	tate of Mai	Cer	tificate of L			g. No.	15555
	Physici	an	1. Decedent's Name (First, Middle, Last) AMELIA	C. I	LINDSAY			2. Date of Death Month	Day Year	3. Time of Death
1000	/Media	cal	4a. Facility Name (If not institution, give stre		TINDSAI	4b. City, Town, or	Location of Dooth	May	02, 2008 4c. County of Death	4:10 a M
	Examir	ier	Gilchrist Center	et and number)		Tows			Baltimo	re
	Funeral		Social Security Number 6. Sex	7. Age (i	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birthp	lace (State or Foreign
	Director		212-22-1543 Usual Residence of Decedent	2991 F	81 Yrs.			Feb. 24	, 1927 Mar	yı́land
	yland how		10a. State 10b. County		Oc. City, Town or Loc	cation			1	0d. Inside City Limits
	e Mar Ba-f sl	ctor	Maryland Baltimor	е	Lutherv	ille				1 □Yes 2 No
	with the	Dir	10e. Street and Number 1121 Longbrook Roa	d		10f. Zip Code 210	าดว	10	ig. Citizen of What Coun	itry?
	ms 23	Funeral Director	11. Marital Status 12.	Was Decedent Eve	r in U.S. 13. V			ecify Yes or No-	14. Race - Americ	an Indian.
336	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar mast be notified at	by	1 Never Married 2 Married	Armed Forces? I □Yes 2 No f Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cubar □Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White, e	etc.
2-0	72 hou natura	Completed	15. Decedent's Education (Specify only highest grade co	on moleted)	16a. Deced	ent's Usual Occupa	ation	ing 1	6b. Kind of Business/Inc	dustry
121	within sne.	Jd m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done d O NOT use retired		ing	O II	
d 2	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	0		Homemake	18. Mother's Name	e (First, Middle, M.	Own Home	
/lan	should be f and Mental I s marked of numatic eve	To B	Harry S	tein			Iola	1	Hornberger	
lar	2 sho and l is ma	ľ	19a. Informant's Name/Relationship (Type.	•	19b. Mailing	g Address (Street a	and Number or Rur	al Route Number,	City or Town, State, Zip	Code)
6, ₹	l and Health em 27 ther tr		Allen R. Lindsay 20a. Method of Disposition	(Son)					land 21122	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination of the profitted at once.		1 M Burial 2 □ Cremation 3 □ Remarks 4 □ Donation 5 □ Other (Specify)	oval from State	20b. Place of Dispos cemetery, crem Cedar Hil	1 Cemeter	y 05 - 0	5-08 B	oc. Location - City or To ${\sf rook1yn}\ {\sf Par}$	k,Maryland
Ball	permit Depari Impori any In		21. Signature of Fun Val Service Licens	Sunt	Mc 3	Name and Addres Cully-Pol 204 Mount	s of Facility Lyniak Fu Lain Road	neral Ho	me P.A. na, Marylan	d 21122
I.			23a Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the	death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Bil	e du	A CA	reer			Onset and Deathy
To the	Examiner			Due to (or as a co	onsequence of):					
7	р <u>н</u>	ner	Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	итвециатке об):					
V	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
68760,	rificate be executed g physician and as the burial-transit			Due to (or as a co	onsequence or).					
289	tificate ng phy. as the	Medical	d							
Вох	eath cer attendir for use	ian/N	in the nast 12 months?	f yes, outcome of p I □ Live birth 2□	Fetal death 3 🗆	Ectopic pregnancy			23d. Date of delive	•
P.O.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician//	1 Tyes 2 William	1 □ Pregnant at tim 1 □ Unknown	ne of death 5	Other (specify)			Month	Day Year
S, T	ires that signed b	by P	Part II. Other significant conditions contribu	iting to death but n	1 2		n in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
ord	w requir been s should	sted	CONTINY 1	YTERY	disens	-Č		1 ☐ Yes	2 ☑No 3 ☐ Prob	ably 4 🗌 Unknown
Records,	m <u></u>	Completed			·			24a. Was an autopsy performe	prior to cor	psy findings available mpletion of cause of
ta	sician: The certificate rector, pag	Be Co	25. Was case referred to medical				26. Place of Deatl	1 □ Yes 2	Ño 1 ☐ Yes	2 2 N o
>	Physical this ce al direc	ToB	examiner? 1 ☐ Yes 2 ☐ No Hosp	tal: 1 ☐ Inpatient	2 ER/Outpatient	Othe	r·	me 5 Residen		Hospice
Division of Vital	Attending Physician: r death. ector: After this certific. by the funeral director.		1 ☑ Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day, Ye	28b. Time of Injury	28c. Injury Work	? _	28d. Describe how	v injury occurred	
1810	r Attendi er death. rector: A by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Place of Injury -	At home, farm, stree		es 2 □No	28f. Location (Stre	eet and Number or Rura	l Route Number
2		Certification:	4 L] Homicide	building, etc. (5	Specify)			City or Town,	State)	
	To the Hospital o within 24 hours af To the Funeral Di completely filled in	Medical	29a. Certifier 1 ☐ Certifying Physicia (Check only one) 1 ☐ Medical Examiner:	n: To the best of m On the basis of exand manner stated	amination and/or inve	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, dat	use(s) and manner as stee and place, and due to	tated. the cause(s)
	Vith Con E	Σ	29b. Signature and title of pertifier	10		29c. License	number	290	Date signed (Month, i	Day, Year)
	, n		30. Na, e and address of person who com-) //	Mem 23a) (Tuno D	rint)	, , , ,	177	70.6 2, 2	008
	10		IN. A. R. ley G.B		101 N-	Charle	St. L	elto. VI	May 2, 2 Md 2, 2	de
	Stat Registra		31. Date filed (Month, Day, Year) MAY 1 3 2008	32. egistrar's	Signeture	we				

DHMH 17 Rev 1/2001

			For State	State of	Marylan		artment of F		d Mental Hy	P P 1	2.0	1
H	Dhisi		Registrar Decedent's Name (First, Middle)	'		001	incate or i	Douth	2. Date of De	eath Day		3. Time of Death
, and	Physici /Medic	al	MARY LOC 4a. Facility Name (If not institutio	KARD	ahor)		4b. City, Town, o	r Location of Do	MAY			1:35P M
	Examin	er	Johns Hopkins	-		Crater		+LTIMON		N/A	, Death	
i sas	Funeral Director		5. Social Security Number 219–12–9839	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. 1 84	last birthday) Yrs.	If Under 1 Year Months Days			th 25 ^{ar)} 1923	9. Birthplac	e (State or Foreign
	e Maryland a-f show tified at	ctor	Usual Residence of Decedent 10a. State N/A N/A		10c. City Bal	y, Town or Lo timore	cation				10d.	. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 5402 Daywalt Avenu	ie			10f. Zip Code 21206			10g. Citizen of W	hat Country USA	?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	ried Armed For 1 ☐ Yes If Yes, Giv	² ₩ No	'	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2♥ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)		- American k, White, etc White	
Maryland 21215-0036	d within 72 hogiene. sr than "natu the Medical	Completed by	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1	-4or 5+)	16a. Deced (Give life. 1 Operat	lent's Usual Occup kind of work done OO NOT use retired	ation during most of v d)	working	16b. Kind of Bus		stry
/land	uld be file Mental Hy Irked othe Itic event,	To Be (17. Father's Name (First, Middle, Martin Trageser	Last)				18. Mother's N Mary S	lame <i>(First, Middle</i> I teadman	, Maiden Surname	a)	
, Mar,	and 2 sho saith and I n 27 is ma er trauma	ľ	19a. Informant's Name/Relations Andrew Trageser/Br						Rural Route Numb W Park Penr		State, Zip Co 1 7352	ode)
Baltimore,	Pages 1, nent of He ant; If iten ary or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		state		sition (Name of natory or other plac Redeemer Cel	1 -	Date 14/08	Baltimore	-	
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service	Licensee (Wellow—		122 53	opard J. Ri 05 Harford	ss of Facility UCK INC Road Ba	ltimore Mar	ryland 212	214	
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition	only one cause on ea	ach line.		er the mode of dyir		diac or respiratory a	arrest,	A In O	pproximate Iterval Between Inset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (o	or as a consequ ASTKO I	uence of): トアセシカ	NAL BL	RED				
/	xecuted and al-transit	Examiner	n any, leaung to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequ	,						
58760,	ficate be executed physician and s the burial-transit	edical E		d								
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 morens? 1 □ Yes 2 □ Mo 9 □ Unknown		irth 2 ☐ Feta ant at time of d	death 3	Ectopic pregnancy Other <i>(specify)</i>	4		23d. Date Mor	e of delivery oth Da	ay Year
Records, P.	w requires that s been signed by should be deta	by	Part II. Other significant conditi	ons contributing to de	ath but not resi	ulting in the ur	nderlying cause giv	en in Part I.		tobacco use contri Yes 2 □ No		cause of death?
	sician: The law re certificate has bee irector, page 2 sho	Completed							— 24a. Was auto perf 1∐ Yes	ppsy pormed?_ d	rior to comp leath?	y findings available letion of cause of
Vital	sician: certific irector,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Magnital:	npatient 2□	ER/Outpatien	, 3D DOA Oth	er:	Death <i>(Check only</i> g Home 5 ☐ Res		(0/-)	
on or	ding Phys h. After this funeral di	tion: To	27. Manner of Death 1 Natural 5 Pendin 2 Accident investi	28a. Date of (Mont)	· – –	28b. Time of Injury	28c. Injui Wor			how injury occurre		
Division or	after death after death Director: d in by the	Certification:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place	of injury - At ho ng, etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location (City or To	(Street and Number wn, State)	r or Rural F	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C		ng Physician: To the Examiner: On the ba and mann	asis of examina							
	To the To the Comp	Me	29b. Signature and title of certifie	1/ P.	·		29c. Licens			29d. Date signed		
)	. A		/ /	who completed cause			Print)	-000		MAYOG		
0	W Sta	ite	31. Date filed (Month, Day, Year	R. PRICE	M.D. Legistrar's Signa		EASTRAN	ANEWE	BALLin	INE, M.D.	. 2122	24
	Registr		MAY 13	2008	an h	1.	and a					

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			For	State of Maryland	d / Depa	artment of H	tealth and	d Mental Hyg	iene	0.00	1 ==== 0
		_ '	- State Registrar		Cei	tificate of	Death		eg. No.	UUU	15558
	Physicia	an	1. Decedent's Name (First, Middle, Last)	MILLE	0			2. Date of Dea Month	Day	Year	3. Time of Death
5	/Medic	al	7 m 07H Y 4a. Facility Name (If not institution, give si			4b. City, Town, o	or Location of De	m A y		nty of Death	
	Examin	er	GOOD SAMF		PI TAL	BA		MORE			
	Funeral		Social Security Number	7. Age (In yrs. II		If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birth Min. (Month, Day March 31,	Year)	9. Birth	nplace (State or Foreign untry) yland
h	Director	}	212-50-2252 1 N Usual Residence of Decedent	6	2 Yrs.			March 31,	1946	Mar	yland
	yland now		10a. State 10b. County	,	, Town or Lo	cation					10d. Inside City Limits
	e Mar	ctor	MD Baltimo	re Bal	timo	ce					1 ☐ Yes 2 XNo
	within 72 hours after death with the Maryland one one	Funeral Director	10e. Street and Number 2902 Northwind	Rđ.		10f. Zip Code 21234			10g. Citizen USA	of What Co	untry?
	ne 23	era		2. Was Decedent Ever in U.	S. 13.	Was Decedent of h	Hispanic Origin?	? (Specify Yes or No-	14. F	Race - Amei	
ထ	or Iter	Fur	1 ☐ Never Married 21 Married	Amed Forces? 1 ☐ Yes 2 XNo If Yes, Give		f Yes, specify Cub 1 □ Yes 2 X No		uerto Hican, etc.)		Black, White ec <i>ify:</i> Wh	
21215-0036	urel',	d by	3 Widowed 4 Oivorced	Year or Dates:							
5	in 72 in 72 in at	Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	Veriz o	f Business/l	industry
212	d with giene.	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)	Tele	ephone 5	Techni	cian	veriz (J11	
pu	be filed ntal Hygie od other	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		name)	
Maryland	should ind Men ind Men in marke	ဥ	Edward Miller 19a. Informant's Name/Relationship (Type	ne Print)	19h Mailie	na Address (Street		nor Jane We		wn State Z	in Code)
	and 2 s saith an n 27 is n		Susan Miller/ W			-		d. Baltimor			.,
re,	s 1 ar	1	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matox or other pla INETaI	ce)	Date	20c. Location		Town, State
Ē	Pages nent of ant: ff lt ury or o		1 ☐ Burial 2 【【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State EVa	ns^Ft pel-	neral Bel Ai	r 05	5/13/08	Fores t	: Hil	1, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department: If them 27 is marked other than "naturel", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Musical Examinar must be multified at once.		21. Signature of Funeral Service License	in grows				Chapel & Cr d. Parkvill			vices
			23a. Part1. Enter the disease, or complic shock, or hear failure. List only on	cations that caused the death e cause on each line.	. Do not en	er the mode of dyi	ng, such as car	rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
)	Physician		rimmediate Cause (Final disease or condition resulting in death)	JEPS	515						Crise, and Death
	/Medical Examiner		Tosoling in doday	Due to (or as a consequ	uence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury	Due to (or as a consequ	sence of):						
	ransit	Examiner	triat initiation events								
,092	te be executed ysicien and e burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
687	ficate physics the l		d								
	h certi	M/W	230. was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal]Ectopic pregnanc	***		23d.	Date of del	
P.O. Box	The law requires that the death certificate be executed has been signed by the attending physicien and page 2 should be detached for use as the burial-trains.	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of do		Other (specify)				Month	Day Year
	that thed by	Ph)	Part II. Other significant conditions con	tributing to death but not resu	alting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use o	contribute to	the cause of death?
rds,	quires tha n signed ud be del	d b	RENAL	FAILUR	E			101	res 2□N	o 3 Pr	obably Unknown
O O	aw requir is been si 2 should	plete	PERITOI	NITIS				24a. Was		4b. Were au	utopsy findings available completion of cause of
Œ E	Physicien: The law r this certificate has wal director, page 2 a	Com						perfo	rmed? 2X No	death? 1 ☐ Yes	~
Vita	icien; certific ector,	Be	25. Was case referred to medical examiner?	ospital:		0:	hor	Death (Check only o			
5	Phys r this oral dir	 7	1 Yes 2 No	28a. ate of Injury	ER/Outpaties 28b. Time of	IL SU DOA	4 🔲 1401311	ng Home 5 ☐ Resid			cify)
ion	nding ath. r: Atte e fune	atlor	1 Alatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2∐No				
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours elter death. To the Funeral Director: Atter this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, st	reet, factory, office		28f. Location (S City or Tox		umber or Ru	ural Route Number,
_	pital ours elected in filled i		29a. Certifier (S Certifying Phys	ician: To the best of my kno	wlados deal	h occurred at the t	ime data and o	stane, and due to the	nausa(s) an	manner ar	stated
	n 24 h	edical		ner: On the basis of examina and manner stated.							
	To the To the To the Comp	Me	29b. Signature and title of certifier	B a L D	111		se number			•	th, Day, Year)
)	1		▶ Marisho	12mm		DOC		(/ -3	MAY		2008
	15		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print) 56	0 1	ORE, N	TVEN	1 130	DULEUARD
	Sta	te	31. Date filed (Month, Day, Year)	\$2. Registrar's Signa	ture	151	CITY	UNE , IY	IFTICL	CINC	0 21451
8,	Registr		MAY 1 3 2008	Filster D.	A. C. S.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death **Physician** Meyer Lonald 11:43 4 MA 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner ANNE Baltimore Washwaton Medical Center 13 LRNI $P(IAD) \in I$ EN Year Age (In vrs. last hirthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Year) 1**∑** M 2 □ F 214-38-7710 Director Aug 3. 1942 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f st dical Examiner must be notified Maryland Anne Arundel 1 ☐ Yes 2 No Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Fourth Ave., S.W. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married 1 ☐ Yes 2 No Specify. 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Joseph Seagram Co. Maryland 21 0 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fealth and Mental I Herman Meyer Ruth K. Wroten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan L. Meyer of Health (Wife) 219 Fourth Ave., S.W., Glen Burnie, Md. altimore, Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State = 5 Important: If any injury o 5/9/08 4 Donation 5 DOther (Specify) Glen Haven Mem Pk Glen Burnie, Maryland 21. Signature of Fundal Service Deensee Kevin E Ecker 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (corrective /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed and ending physician and use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 12 No 23d Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? chrunic chrtructine lung diceal artery disease. 2 No 3 Probably 4 Unknown obstructive sup a prea 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0022483 May 5, 2008 MD leted cause of death (Item 23a) (Type, Print) 30. Name and address of person Neight of he Glen Burnie, MD 2106/ 305 mn

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Virginia Beth Margan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03465 State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State 3. Time of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1100 hrs May 6, 2008 Morgan Medical Examine Virginia Beth c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville 263 Congressional Lane Apt. 401 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex New Foreign **Funeral** Months Days Hours OCT 25 1948 Jersev Director 59 Yrs 2 **X** F 526-78-1930 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County in, 10a State 1 Yes 2 X No Rockville s 23a or 28a-f show e notified at once. Montgomery 10g. Citizen of What Country? Director 10e, Street and Number 20852 Apt. 401 263 Congressional Ln., 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or item injury or other traumatic event, the <u>Medical Examiner must b</u> 1 X Never Married 2 X No Yes Specify: White Yes 2 X No specify: f Yes. Give Year Widowed 16b. Kind of Business/Industry à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Medical Research Elementary/Secondary (0-12) College (1-4 or 5+) Institution Writer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dunlap Mary Be Howard Ε. Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WA Apt.35-203 Olympia. SW. sister 1100 Fern St., Jessica G. Morgan, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Burial 2 X Cremation 3 Removal from State 05/09/08 Baltimore, MD Metro Crematory, Inc. Donation 5 Other Specify: 22. Name and Address of Facility Cremation Society of 21. Signature of Funeral Service Licensee George MacNabb Inc . MD Baltimore, 299 Frederick Road an m Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical Amitriptyline intoxication Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X #EXP. 27, 28a-f perME, g879 5/15/08 TT /#5, perFH, C879, 5/22/08, WS g physician a Y UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760 IF FEMALE: Month Day Year 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death / the attending p Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. After this certificate has been signed by funeral director, page 2 should be detach 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy death? performed? 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other4 Nursing Home 5 Residence 6 ✔ Other: Scene examiner Hospital: 1 DOA FR/Outpatient 3 Inpatient 2 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fun subject overdosed on drug Natural Pending Fnd5/6/2008 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 263 Ongressional In. Rockville, MD 3 y Suicide Could not be (Specify) Fnd residence determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier May 7, 2008 O.C.M.E. ms 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Was), Year) State Collins . Registrar

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DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryand 10879 15/13/08 Wealth and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician** lians 2008 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Min Maryland Director 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Zes 2 No timore Funeral Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) 5th College (1-4or 5+) Elementary/Secondary (0-12) Elde Keliaion 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be William Milbourne 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health of Important: If item 27 is any injury or other tra AliceMil Date 20b. Place of Disposition (Name of 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State RKWOOD (eneter 21. Signature of Funeral Service Licensee 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. M0136 such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) intra **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 3 Probably 4 Unknown 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient Yes 2□ No Certification: To 1 | Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6/2008 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) Grood Samantan Horpital, MD 21239 CALATHIL SHASHIDHARAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MUBEURNE

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rock Glen Nursing Home NIA Baltimore If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213.30.1607 1**X**M 2□ F Months Days Hours MD 07 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show Baltimore MD 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5616 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Health and Mental Hygiene. iem 27 is marked other than "natural", or item other traumatic event, the Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TKNo Specify ð Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)

9th grade College (1-4or 5+) LABORER of Man 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edward Annie Stokes Mc Crav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Baltimore MD 21215 Sister Smith 5616 Eldern Department of Health Important: If item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 05/15/08 Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Valighn C. Greene Funeral SVCS Vaugh Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute /Medical Due to (or es a consequence of) **Examiner** VD Sequentially list conditions, if eny, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate ! perform 1 ☐ Yes 2 No 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Machinian Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) slawst Ballimore

Registrar DHMH 17 Rev 1/2001

State

AHMED

3

2008

31. Date filed (Month, Day, Year)

MAY

MD

32. Registrar's Signature

821

N.

08-03611 William Clark Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Cert	tificate c	of Death			Reg. N	No.	000 15-
Physicia edical Exami	ın/	1. Decedent's Name (First, Middle,Last) William Clark Miller				Me Ma	nte of Death onth Da ny 11, 2008	3	3: Time of Death
		Facility Name (if not institution, give street and number) 4252 Mt. Carmel Road		4b. City, Town, Upperco	or Location of	f Death		4c. County of Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lat 146–18–9834 1X M 2 F	st birthday) Yr	If Under 1 Ye Months Da		_	Date of Birth (Marge 23,		g. Birthplace (State or Foreign Country) Penn.
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland pages I and 2 should be filed within 72 hours after death with the Maryland fant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	I Directo	Usual Residence of Decedent 10a. State	Town or Loca Upper 3. 13. W 1 1 16a. Decede during i Sal	/as Decedent of H Yes, specify Cub Yes 2XX N ent's Usual Occup most of working li	21155 dispanic Orig an, Mexican, No specify: pation (Give k fe. DO NOT	in? (Specify Puerto Ricar kind of work d use retired) s Name (Firs anor S	Yes or No- n, etc.) one 16 W t, Middle, Maid	Citizen of What U.S.A. 14. Race-White, Specify: b. Kind of Bus (hite P den Surname) Kookag	10d. Inside City Limits 1 Yes 2 No at Country? American Indian, Black, etc. White Iness/Industry Cleaner Cleaner ee
Balt permit Depart Impor		1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	rematory or o	Name and Address 296 Char	ess of Facility mil Dr	Eckhar • Mano	dt Fun hester	Balti eral C	201 1 22 1 25 1 25 1 27 2
Physician /Medical * Examiner	лег	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. CDntact Gunshot Wound Due to (or as a consequence of Due to (or as	d of Head):		ig, such as ca	ardiac of rest	matory arrest,		rt Approximate Interval Between Onset and Death
760, icate be executed physician and the burial - transit	Medical Examiner	Couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last unpended Unpend	379 5 . 13	3/08 TT					
Box 68760, he death certificate by the attending physic hed for use as the but	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the pregnant at time of deal yes unknown 4 Pregnant at time of deal yes unknown	2	Other (Specify)	transer of	pregnancy		23d. Date of (Day Year
Records, P.O. Box 68' The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by F	Part II. Other significant conditions contributing to death but not re	esulting in the	e underlying caus	e given in Pa	_		2 No 3	bute to the cause of death? Probably 4 Unknown Vere autopsy findings available into to completion of cause of eath?
, , , = -	Be Com	25. Was case referred to medical examiner?		26.Pla		(Check only	1 ✓ Yes 2		Yes 2 No
_ = . ~ 2	은	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation May 11, 2008	28b. Time o FOUND: 1120 hrs	f Injury 28c. Ir	Other at Work Yes 2	. ISub		injury occurre	Other: Scene ed
Division Hospital or Attendi 24 hours after death. Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Barn		reet, factory, offic	e building, et		or Town, State		er or Rural Route Number, City erco, MD
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledgenee 2 Medical Examiner: In the basis of examination are 29b. Signature and title of certifier		gation, in my opin			time, date and	d place, and di	
OCME		30. Name and addless of person who completed cause of death (Item	23a)		C.M.E.			May 12, 20	
	ate	Mary G. Ripple MD. Deputy Chief Medical Exan 31. Date filed (Month, Day, Year) 32. Registrar's Signatu	niner 1	11 Penn Stre	et, Baltim	ore, MD 2	1201		
Regist		MAY 1 3 2008 House It		als!	-				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Physician CLEONE FRANCES McCALL 10, 6:55 A M MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPICE DOVE HOUSE CARROLL WESTMINSTER If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 □ M 2 🗓 F Director 420-34-5476 77 10/10/1930 ALABAMA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No CARROLL HAMPSTEAD Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3849 DAKOTA RD. 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: by 3 ☐ Widowed 4 N Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN FOOD SERVICE 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOIS ALLEN DAISY F. DIVINE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Physician /Medical STEPHEN ANDERSON - SON

1 X Burial 2 □ Cremation 3 X Removal from State

20a. Method of Disposition

Baltimore, Maryland 21215-0036

Examiner

nding physician signed by t d be detach After within 24 hours after death.

To the Funeral Director: /

The law requires that the death certificate be executed

To the Hospital or AttendIng Physiclan:

Division or Vital Records, P.O. Box 68760, &

	4 □ Donation 5 □ Other (Specify	v) B ¢U G <i>I</i>	AWVILLEA	CEM. 5/1	4/08 AVC	N PARK	, FL
	21. Signature of Funeral Service Licen	nse	22. Name a	and Address of Facility FL	ETCHER FU	NERAL F	HOME. P.A.
	1 Jan High	Isala	254 E	. MAIN ST.	, WESTMIN		1D 21157
	23a. Part1. Enter the disease to company shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter the mo	de of dying, such as cardiac	c or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. End Due to (or as a consequence of the conseque	Stage lence of): 8	C. O. P.	D		Onset and Death
iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	rence of):			- 3	1
Exam	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):				
dical		d. C (K ·)	Δ			-	
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic			23d. Date of de Month	livery Day Year
ed by Ph	Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacci		o the cause of death?
Complet	_				24a. Was an autopsy performed? 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?				ath (Check only one)		
ပ	1 ☐ Yes 2 ☐ ₩6	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3□ □	OA Other: 4 Nursing H	lome 5 ☐ Residence	6 XOther (Spe	ecify) HOSPICE
ation:	27. Manner eath 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Sertific	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, street, facto '/	ry, office	28f. Location (Street City or Town, St		ural Route Number,
Medical Certification: To	29a. Certifier 1 Dertifying Ph (Check only one)	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
M	29b. Signature and title of certifier	ienea 1	ND 3	oc. License number) - 00543	218 29d. [Date signed (Mon	th, Day, Year)
	30 Name and address of person who	B. Kanen	, 3491	Nolcalm D	nive, WE	STMENS	TER, MD
	31 Date filed (Month, Day, Year)	32 Renistrar's Signat	TURE				

3849 DAKOTA RD., HAMPSTEAD, MD

Date

5/14/08

21074

20c. Location - City or Town, State

State

Registrar

31. Date filed (Month, Day, Year)

MAY 13

2008

anen 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day MARVIN LEO MANN 4:00 P M 12, MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL UNION BRIDGE 309 CLEAR RIDGE RD. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/21/1936 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2□ F Months Days Hours Min. 218-32-6599 Director MARYLAND Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No UNION BRIDGE Director MD CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21791 USA 309 CLEAR RIDGE RD. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after r nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XINo If Yes. Give Specify. Completed by Specify: 3 Widowed 4 Divorced WHITE Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POSTAL SERVICE MAIL CARRIER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FLORENCE REED MYERLY ROY MILTON MANN မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 CLEAR RIDGE RD., UNION BRIDGE, MD 21791 VIRGINIA MANN - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot ty⊒ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 5 □ Other (Specify) EVERGREEN MEM. GARDENS FINKSBURG, MD 21. Signatur of Fune of Survice Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Partz Enter the disease, or complications that caused the death. Do not enter the most e of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, the attending physician sed for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I □Yes 2 □ No Division of Vital Records, P.O. 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performe 2 No 1 □Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier em 23a) (Type, Print 30. Name ar 31. Date filed (Month Registrar's Signature Registrar

Physicia		1- For State Registrar			Cer	tificate o	f Death				eg. No.	2 U	98	1556
Medical Exami	2111/	Decedent's Name (F							. Date of Dea Month	Day	Year	3. Time of 1024		
wedical Exami	ner	James Paul Morgan 4a. Facility Name (if not institution, give street and number) 4b. City, Town,								May 10, 2		County of Deat		
		5 Windmill Ch	49. Facility Name (if not institution, give street and number) 5 Windmill Chase Apt. A								Ва	Itimore Co	unty	
Funeral Director		5. Social Security Num 213-52-87	705 ₁ X	M 2 F	7. Age (In yrs. last birthday) 2 F 59 Yrs			ear If Unde ays Hours				h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD		
any		Usual Residence of De 10a. State 10	Decedent Ob. County		10c. City.	. Town or Loca	tion						10d. Insi	de City Limits
\$	L	MD	Baltimo	irks						1 Yes 2 No				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	cto	10e. Street and Numb	per		1		10f. Zip Code	9			0g. Citize	n of What Co	untry?	
	Director	5A Windmi	ill Chase	e				21152		USA				
	Funeral	11. Marital Status		12. Was Decede			as Decedent of es, specify Cul	Hispanic Orig				4. Race - Ame White, etc.	ncan India	n, Black,
r deat	Fu	1 Never Married		1 X Yes	2 No									
s aftel ral",	by	3 Widowed 15. Decedent's Educ	4 X Divorced	or Dates:	ompleted)	1 L	Yes 2 X			rk dono		pecify: Wand of Business	hite	
"natu Exar	Completed	Elementary/Second		College (1-4 c			nost of working				TOD. KII	id of business	onition y	
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5-0036 iled within 7 Hygiene. I other than the Medica	Con	17. Father's Name (Fi	irst, Middle, Last)							First, Middle,				
215 be file ntal H rked c	Be (Everett W	Wesley Mo	organ				He	len 1	Marie	Kotso	n		
ould d Mer	٥	19a. Informant's Name	e/Relationship (Ty	ype, Print)		19b. Mailir	g Address (Si	reet and Nun	nber or Ru	rai Route Nu	mber, City	or Town, Sta	te, Zip Cod	e)
MD d 2 sho ulth and n 27 is aumati		Mary Kath		rgan/for			10700	Lakesp	ring		Cocke	ysvill	e, MI	21030
Fe, s I am		20a. Method of Dispos	Sition Cremation 3	Removal from		Place of Dispo crematory or o	sition (Name of ther place)	cemetery,		Date	20c. Lo	ocation - City o	or Town, St	ate
Page:			Other Specify:			tro Cr	ematory		5/1:	2/08	Cat	onsvil	1e, M	D
Baltimore, permit. Pages I ar Department of Here Important: If ite		21. Sign sture of Func	eral Service Licens	see		22. T	Name and Addr	ess of Facility	V					W.772
	1. 3	Bryan W. Clary Lemmon Funeral Home of Dulaney Val 10 W. Padonia Rd., Timonium, MD 2100 23a. Part I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										<u>ib 2144</u>	$\frac{e^y}{3}$	nc.
Physician (Madian)	4	23a. Part I. Enter the failure. List only	disease, or compl one cause on each	lications that caus ch line.	ed the death	n. Do not enter	the mode of dyi	ng, such as c	ardiac or	respiratory ar	rest, shoc	k, or heart		en Onset and
/Medical xaminer	8 8	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease or condition resulting in death) Due to (or as a consequence of):									-	Death		
			, b	Due to (or as a co	risequence (JI).								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
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18760, rtificate be executed ing physician and as the burial - transis		UNPENDED IF FEMALE: 23b. Was decedent pro	eath) Last d	· · - · · · · · · · · · · · · · · · · ·	come of preg	gnancy	/08 TT	3 Ectopi	c pregnan	су	1	Date of delive	ery Day	Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 9879 5-16-08 vt. State of Maryland? Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Yea 10 Physician 05 2008 0 /Medical 4c. County of Death Town, on Logation of Death 4a. Facility Name (If not institution, give street and number) Examiner INDI 8. Date of Birth (Month, Day, If Under 24 Hrs. if Under 1 Year 9. Birthplace (State of Country) West. 5. Social Security Number 6. Ses 7. Age (In yrs. last bi or Foreign **Funeral** Months Days Hours 1**⊠**M 2□F 221-24-1088 Yrs. Director SINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code HEIGHTS Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CITY OF BALTIMORE tousing 18. Mother's Name (First, Middle, Maiden Sarname) 17. Father's Name (First, Middle, Last) Be HERMAN ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D.C. 20018 ASHINGTON VARSULVIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐Removal from State -08 CROWNSVILLE ROWASYILL 4 Domation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Dicensee BALTO. MD 21217 2 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or 😿 a consequence of): Examiner tequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical IF FEMALE: use 23c. if yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 2 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, δ 1 Yes 2 No 3 Probably 4 ☐Unknown funeral director, page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 25. Was case referred to dical examiner? 1
☐ Yes Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours after death Puneral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ပ 3a) (Type, Print) 31. Date filed (Month, Day, Year 32 egistrar's Signature State MAY 13 2008 Registrar

Baltimore, Maryland 21215-0036

1 - For State Registrar

Physician /Medical Examiner and

Box 68760. P.O. Division of Vital Records.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AY 7, 2008 **Physician** McCAULEY MARY MAY MAY 11:30p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 6 Sex **Funeral** ntry)
T VIRGINIA 1 □ M 2 X F Months 220-18-9756 Yrs. 96 Director Usual Residence of Decedent 10a, State 10c. City. Town or Location 10d, Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with I and Mental Hygiene.

is marked other than "natural", or items 23a or 3 12A CEDAR DRIVE 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ko If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONTINENTAL CAN 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAFAYETT LAMBERT ဥ DAISY HIGGINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i JUANITA McCAULEY/DAUGHTER 113 COVERED WAGON RD., BALTIMORE, MD. 21220 Pages 1 ament of Hr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any Injury or o Burial 2 Cremation 3 Removal from State HOLLY HILL CEMETERY 5/12/08 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
LLY & ZEILER
01 EASTERN A R INC. FUNERAL HOME AVENUE, BALTIMORE, MD. 1901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) necmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 1 □Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 □ Nursing Home 5 □ Residence 6 ★Other (Specify) WOSPICE Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of After t 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) Natural 5 Pending To the Hospital or Autoriantin 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fronces AALON 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State MAY 13 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 6, 2008 **Physician** 4:45 PM M George J. Majus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**0M 2□F Yrs. 70 1938 Pennsylvania 205-28-7953 Director Usual Residence of Decedent 10d Inside City Limits 10a State 10b. County 10c. City. Town or Location tr is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√☐ No Director Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 9715 Healthway Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Oc / 2005 / / ... Maryland 21215-0036 white 1 ☐ Yes 2K No Specify: Specify: φ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na. any injury or other traumatic event, the Meuler 2006. Elementary/Secondary (0-12) College (1-4or 5+) sheet metal 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Genevieve Carr John Majus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1211 Elsea Smith Road Independence, MO 64056 Kimberly Majus/spouse DOO OS / Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature Funeral Serve S. Wade A Director State Anatomy Board 655 W. Baltimore Street my Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Oxygen Dependent Chance Obstrutive Pelmon Immediate Cause (Final disease or condition resulting in death) Find Sture Physician Trees /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) after death.
i Director: Alter this certificete has been signed by the ettending physician in by the funeral director, pege 2 should be detached for use as the burian Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Creorge THayus 208-28-7963 Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Discare 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes Man 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 🔲 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C
completely filled 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 (08 completed cause of death (Item 23a) (Type, Print) Coastal Hyling Rewet Felend De 19944

DHMH 17 Rev 1/2001

State Registrar

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1209 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 20b, perFh.g879 5/13/08 TT Certificate of Death 3. Time of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death ASIT Month **Physician** Year S /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pasadena 7813 East Rd. Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Year) 1 □ M 2 F 87 Sept. 219-14-1754 18 Maryland Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Examiner must be not the dis-1 □Yes 2 XNo Director fid. Arme Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 7813 East Rd. 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify þ Yes Give Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evers ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7813 Ea<u>st Rd. Pasadena, Md.</u> <u>Lena Vincent</u> (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 2008 Pages nent of h permit. Pages Department of important: if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 5/14/05Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera Service Lo nser 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ears /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) P.O. ed by the detached 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate Division of Vital 1 ☐ Yes 2 🖼 No 1 ☐ Yes 2 ☐ No or Attending Physician; After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner space. 29a. Certifier Medical (Check only one) 29c. License number ì

State Regist<u>rar</u> DEFENSE HGHWAY

leted cause of death (Item 23a) (Type Print)

32. Hegistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 1025 AM Year Nielsen Taylor 05 2008 02 4a. Facility Name (Il not institution, give street and number)

Nhortor River Wanor 200 morgnec Road 4b. City, Town, or Location of Death 4c. County of Death Chestertown MDZ1620 Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Mary Land 214-30-779 01-05-1934 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Kent Chestertown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Burchard Sawmill Road 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) licensed practical nurse healthcare 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Corydon Taylor Sr Helen Frazier 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chester River Manor 200 Morgnec Road Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) celicensee S. Wade, Director 21. Si parture Leuneral Ser 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO PULLICARY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Righ linen label MHASTATIC Careciliona to BEATA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an OBStructure 1□ Yes Hnouse 2 - No Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA

Physician /Medical Examiner

that the death certificate be executed

Box 68760.

P.O.

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the Hospital or Attending hin 24 hours after death.

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event. the Ma

Physician

/Medical

Examiner

Funeral

Director

28a-f show at

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Baltimore, Maryland 21215-0036

Director

Funeral

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State Registrar

ess of person who completed cause of death (Item 23a) (Type, Print)

ARKABAL TR M.) 18 Sheet CHestertown, Ald 21620 223

State of Maryland	Department of Health and	d Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** DREW P. OWENS **April** 2008 11:39 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takona Park Montgamery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**X** M 2□ F Director 12-18-1951 282-48-7792 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mantel Hygiene. Important: If item 27 is marked other then "neturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examiner must be excitled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Adelphi Princes Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2611 Lackawanna Street 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: African-American þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State highway Admin. Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harding Owens Sr. Blanchie Bridges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla A. Owens/Wife 2611 Lackawanna Street, Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-5-08 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery diverse herosclerotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ${\mathbb S}$ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has I director, page 2 s autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ctor: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Directompletely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my options. Medical 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52326 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll Avenue, Takona Hora. LightFoot Di. James K. 7600 31. Date filed (Month, Day, Year) ₩egistrar's Signature State Sperte Registrar 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Sandra Ann Oldaker 3:45 Ам May 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center For Hospice Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Date of Birth (Month, Day, Year) 1 □ M 2 🔀 F Months Days Hours Min. 216 66 3003 53 Director June 11,1954 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience must be notified at Maryland Baltimore Middle River 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Glider Drive 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ģ Specify. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Clinical Research Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Henry Oldaker Marie Virginia Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Oldaker (Brother) 117 Glider Drive Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 5/14/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service bicensee Kn W Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Page 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** aweeks disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, metastases to brain 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Momina 1 □Yes 2 XNo 26/08 28f. Location (Street and Number or Rural oute I lace of Injury - At home, farm, stree, factory, office building, etc. (Specify) 6 ☐ Could not be 4 Homicide 117 Glider D /Middle River 21 200 hom e To the Hospital within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 555 W. Towson

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lendall Ritaulkner

31. Date filed (Month, Day, Year)

25643

Balto My

			1	State of Maryland / Department of Health and N - For State Registrer Certificate of Death		giene 3eg. No. 2008	15575
				Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ath Day Year	3. Time of Death
		Physicia /Medic		Clara Elaine Pasterfield	May	11, 2008	7:05 P.M
	1	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	l	4c. County of Deat	1
				Maryland Masonic Home Hunt Valley 5 Seek Seewith Number 5 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birtl	Baltimor	e County pplace (State or Foreign
	п	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. Age (In yrs. last birthday) 4 Wonths Days Hours Min.	8. Date of Birtl (Month, Day Feb. 25	v, Year)Co	inore, IID.
		Director		Usual Residence of Decedent			Carl Link Ob. Links
		how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
		after death with the Maryland or Items 23a or 28a-1 show other must be mailised at	Funeral Director	Maryland Baltimore County Hunt Valley		10g. Citizen of What Co	
		vith th		106. Street and Number 10f. Zip Code 21030		United Sta	
		9ath v	era	300 International Circle 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Some Hispanic Origin) (Some His	pecify Yes or No-		nican Indian,
)			Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 🛱 No	o Rican, etc.)		
3	93		ρχ	If Yes, Give Year or Dates: If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify:		, , , , , , , , , , , , , , , , , , ,	hite
Cean	21215-0036	within 72 hours after death wene. ene. than "natural", or Items 23a the Medical Exeminer matte	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	rking	16b. Kind of Business/	Industry
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3	d 2	Hygid Hygid Sther ant, II	C		ne (First, Middle,	Maiden Sumame)	
3	<u>la</u> n	Ald be Aental rked c	To Be	Michael Schneeberger Katherin			
MStayren	Maryland	s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene. item 27 is marked other than 'natural', other traumatic event, the Madical Ext		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			
157	Σ,	and 2 eaith m 27 her tra		Mrs. Joan P. Bourne (Daughter) 15812 Ensor Mill Road 20a Method of Disposition (Name of	Spark	s, Maryland	
C	ore	ges 1 it of H if itel or otl		1 Burial 2 Toremation 3 Removal from State Commetery, crematory or other place) May	13,	Forest Hil	
	Baltimore,	it. Pa rtmen rtant: njury		4 Donation 5 Other (Specify)			
	Ba	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 2005s.		Man A Mar. 2325 York Road			21093
	760,4	heath certificate be executed with the state of the state	Medical Examiner	23a. Part Ener the disease or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, of heart failure. List only one cause off each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		23d. Date of de	Interval Between Onset and Death
	P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
	rds, F	w requires tha been signed should be de	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ly parters: Phermitors are allerts, Osteoporusi			robably 4 X Unknown
	Division of Vital Records,	ding Physician; The law re n. After this certificate has be funeral director, page 2 shc	Completed	adult Faile To Trive Symbone, Deneution		s an 24b. Were a prior to death? 2 \(\) \	autopsy findings available completion of cause of
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	of \	hysic this c	2			idence 6 Other (Sp. how injury occurred	ecify)
	u C	ding F	tlon	1 Natural 5 Pending (Month, Day Year) Injury Work? 1 Natural 5 Pending (Month, Day Year) Injury Work? 1 □ Yes 2 □ No			
	isi	death death ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		(Street and Number or Fown, State)	Rural Route Number,
	Ö	al or / s after il Dire	Certification;	4 Homicide building, etc. (Specify)	J Only 61 10		
		To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, date of my knowledge, death occurred at the time, date of my knowledge, date of my knowledge, date o	e, and due to the curred at the time	e cause(s) and manner a , date and place, and du	as stated. ue to the cause(s)
_		To the vithin To the compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	-
				Pary Dary 64		5/12/08	?
		12		30. Name and address of person in a completed caute of death (Item 23a) (Type, Print)	1212	116	
		1.		POBERT 21BERTO, WD. 3508 Bank St. Ballo, No. 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	1 = 10	07	
		St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature MAY 1 3 2008			

			For State	State of M	/laryland	•	artment of F	lealth and N	lental Hy	_	0.0.0	
			Registrar 1. Decedent's Name (First, Middle, L	ast)			Timeate of i		2. Date of De	Reg. No.	U U 8	3. Time of Death
	Physicia		Herbert Lei	,	=				Month May	9, 200	Year 8	1:25 AM
Andr.	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Death		4c. County	of Death	
مهد			Gilchrist Cer	ıter			Towso				.more	
	Funeral Director		5. Social Security Number 6. 215-09-9037	Sex 1,	Age (In yrs. la	ast birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October	th ay, Year) 12,1918_	Coun	place (State or Foreign atry) yland
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation				1	0d. Inside City Limits
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	r 28a	Director	10e. Street and Number		-	<u> </u>	10f. Zip Code			10g. Citizen of	What Coun	itry?
	th with	a D	8403 Awandale	Road			21234			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mydical Extrativational be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 XYes 2 [If Yes, Give Year or Dates	s? ⊒No		Was Decedent of H f Yes, specify Cuba I □Yes 2🏋 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra Bla Specit	ce - Americ ck, White, c y: Wh	
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Baltimore, Maryland 21215-0036	ild be file fental Hy rked oth ic event	To Be (17. Father's Name (First, Middle, Las Martin Phipps	it)				18. Mother's Name Edna Ru		, Maiden Surnai	ne)	
Mary	d 2 shouth and N	(%)	19a. Informant's Name/Relationship Maxine Phipps/			1	_	and Number or Rui				Code)
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D. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after clearly. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	n 2 ☐ Fetal t at time of de	death 3	Ectopic pregnand Other (specify)	sy			ate of delive onth	ery Day Year
σ.	that the		Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	tribute to the	he cause of death?
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Division of Vital Records, P.O.	sician; The law certificate has rector, page 2 s	Completed by							auto perfe 1 □ Yes	pred2 2 🗆 No	prior to co death? 1 □ Yes	mpletion of cause of
ξ	sicial s certi irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 🗆 E	ER/Outpation	ot all DOA Oth	26. Place of Deal		one) idence 6 ⊈Ot	box (Cook)	· Hospice
0	g Phys er this eral dir	n: T	27. Manner of Death	28a. Date of Ir	njury	28b. Time of				how injury occu		W) 110-7-5C
<u>0</u>	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigat		Day, Year)	Injury		Yes 2 □ No				
<u>N</u>	or Attending Ptater death. Director: After the in by the function	Certification: To	3 ☐ Suicide 6 ☐ Could not determine	be 28e. Place of building,	Injury - At hor etc. (Specify	me, farm, str	eet, factory, office			(Street and Num	ber or Rur	al Route Number,
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	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edical	29a. Certifier 1	Physician: To the be aminer: On the basis and manner	s of examinati	wledge, deat ion and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occur	, and due to the rred at the time	e cause(s) and r , date and place	nanner as s , and due te	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 1-0			29c. Licens	se number	-	29d. Date sign	-	
			10/1 frot	my Kill	7.0	NO.	12	3 203		MAY		2008
	5		30. Name and address of person wh	GAM	death (Item	23a) (Type,	Print) N. Clu	roles St	- Bal	Ho. n	ld 7	2,20 K
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 3 2	32 Regis	strar's Signat	ure do	and a					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Alice Kosela Mac 2008 12 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death University Maryland N/A Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day,) Aug. 20 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday))^{Year)}1937 Months Days Hours 1 ☐ M 2 🔀 F 70 Aug. 238-60-7153 NC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7732 Central Avenue 21122 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aid State Agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, William McDuffie Gilchrist <u>Annie</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Antonio G. Rosela Sr. (spouse) 7732 Central Avenue, Pasadena, MD 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Maryland Veterans Cent. 2008 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) sels sis Due to (or as a consequence of): Acineto bacter neumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of reshire Due to (or as a consequence of 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 0 Lisease 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Directo

Funeral

Completed by

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and attending physician for use as the burial funeral director, page 2 should be detached this After after death filled in by the

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 9 Unknoy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Shvark

2008

within 24 hours a To the Funeral L

29c. License number

22053

Greene Str.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Medical Center view -imove Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Director nce of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examinar must be notified at 1 es 2 No Director timore 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. y/Secondary (0-12) College (1-4or 5+) 17. Father's 18. Mother's Name (First, Middle, Maiden Surnam Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Drughter) Tv20b. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Isaltimore, MD 21. Signature of Funeral Service Licensee MD1363 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** ummar /Medical ue to (or as a cons. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Slive heart Failur) Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of). P.O. Box 68760, attending physician the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 performed? this certificate 1 ☐ Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rown Bled, Ba MI

Registrar

31. Date filed (Month, Day, Year)

13

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08 Day 2008 ear Marth 00P, M William E. Regan, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Berlin Berlin Min. 10106 War Admiral Lane Worcester If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F 67 Yrs. 219-38-0466 Sept. 17,1940 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No MD Worcester Berlin 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10106 War Admiral Lane 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Computer Software Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Regan, Sr. Louise Kipke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June R. Regan/Wife 10106 War Admiral Lane Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley 20a. Method of Disposition 20c. Location - City or Town, State May 13. 1 X Burial 2 ☐ Cremation 3 Removal from State 2008 4 □ Donation 5 □ Other (Specify) Memorial Gardens Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Lemmon Funeral Road Timonium, MD 21093 21. Signature of Funeral Se ehael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Due to (or as a consequence of) ASCVD Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hyperlipidemia Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

be executed

death certificate

P.O. Box 68760

Division or Vital Records,

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

Funeral

Director

show

d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

72 hours after

iges 1 and 2 should be filed very filed very filed to the alth and Mental Hygic If Item 27 is marked other?

Department of Hear Important: If the any init. injury or other

Maryland 21215-0036

Baltimore,

burial-trar the as director, funeral

and Physician/Medical ≥ Completed Be

physician ed by the attending detached for use as signed t been signature cate has t certificate Certification: To this After death. after death filled in by 24 hours a

within 2. Registrar

Hospital

the

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) Injury

and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

> 29c. License number D12405

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

10. 140. C. AUGSLL. MD. 10755 FALLS NJ., BALTIMONE, MD21093

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 05/07/2008 7:30 РМ Warren L. Robertson, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1217 Leonard Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Days Min 1**X** M 2□ F 08-28-1925 Yrs. 230-24-5447 VΑ **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "nature." 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1217 Leonard Drive 21060 U.S.A. Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give white If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify þ 3K Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther D. Robertson Nettie Staples 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lois Hopf / daughter 6505 Home Water Way; Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩XBuria! 2 Cremation 3 Removal from State Maryland Vets. Cem. Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 5-13-2008 21. Signature of Service Lice 22. Name and Address of Facility Singleton Funeral & Cremation de reduce Services 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mus cardia **Physician** /Medical Que to (or)as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 **N**o 1 | Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Certification: To After this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signafture and title of certifier 12161 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Loraine Dailey 24 A Magothy Beach Road Pasadena MD 21122

32. Pegistrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ith Medical Exemples in the tectified at any Injury or other traumatic event, Ith Medical Exemples in the tectified at any Dines.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	-	For State Of IV State Registrar	iai yiaiiu / i	Certific			i Wentai my	Reg. No.	2008	3 1558			
icia		1. Decedent's Name (First, Middle, Last)			10		2. Date of D	eath Day	Year	3. Time of Death			
dica		ROGER TAYLOR		OLL!	NS		MAY	08	2008				
nine	r	4a. Facility Name (If not institution, give street and number	2 V1 m. 16	4b. C	ity, Town, or	Location of De	ath _	4c. Co	unty of Death				
al		5. Social Security Number 6. Sex 7. A	ge (In yrs. last bii		der 1 Year	If Under 24 H	rs. 8. Date of B	rth , ,	9. Birth	place (State or Foreign			
or		217 - 81-2118 XX M 2□F		Yrs. Mont	hs Days	Hours M	rs. 8. Date of B n. (Month, P 4/22/	98 (Year)	9. Birth Cou MD	intry)			
		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits			
	ō	MD AA	Glen B							1 ☐ Yes_2 ☐ No			
	<u> </u>	10e. Street and Number		10f.	Zip Code			10g. Citize	n of What Cou	4141			
9	Funeral Director	1725 Saunders Way			21061			US	A				
	ine.	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S.	13. Was De	ecedent of H	ispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0- 14	Race - Ameri Black, White,				
	ਨ∣	1 Yes X2 If Yes, Give Year or Dates] No		s XXNo	Specify:	o, to 1 llocal 1, o.to., j			white			
	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	. Decedent's L		ation during most of v	mrkina	16b. Kind	of Business/Ir	ndustry			
	ᇤ	Elementary/Secondary (0-12) College (1-4or	5+)	life. DO NO	T use retired	iding most of v	rorking	DIA					
	ទី	17. Father's Name (First, Middle, Last)		None		40 Matharia N	lame (First, Middle	NA Maidan Su	renamo)				
	Re	Rocky R.L. Rollins					sha	A .		helnutt			
F	2 │	19a. Informant's Name/Relationship (Type. Print)	198	o. Mailing Addr	ess (Street	and Number or	Rural Route Num	ber, City or T	own, State, Zi	ip Code)			
		Rocky Rollins (father)	1	725 Sau	ınders	Way G1	en Burni	e, MD	21061				
		20a. Method of Disposition 1/□ Burial 2/□ Cremation 3 □ Removal from State	20b. Place o	of Disposition (Name of or other place	re)	Date	20c. Loca	tion - City or T	own, State			
		Donation 5 Other (Specify)	Chesap			on 5/			er, MD				
once		21. \$ignature of Funeral Service Licensee	100305		0		al & Cre Burnie,		Servi 1061	ces			
		23a Part 1. Enter the disease, or complications that cause	ed the death. Do							Approximate Interval Between			
n		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Externe Prematurity											
al		disease or condition resulting in death) a. Due to (or as a consequence of):											
er	_	Sequentially list conditions, b.	evere	Kespi	rater	y Usi	vess So	indr	eme	17 days			
	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence	of):		(·			
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	Medical	IE EEMALE.											
1	an/l		2 Fetal deatl	n 3□Ectop	oic pregnanc	у		23	d. Date of deli	very Day Year			
-	by Physician/I	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death	5 ☐ Othei	r (specify) _				MOTAL!	buy Tour			
Ī	7 7	Part II. Other significant conditions contributing to death	but not resulting i	n the upderlyin	ng cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?			
		Intraventic	ular	1+0	mon	Mage	10	Yes 2	No 3□ Pro	obably 4 🗌 Unknown			
-	Completed						24a. Wa	s an	24b. Were aut	topsy findings available ompletion of cause of			
	S						per 1 □ Yes	formed? 2 No	death? 1 □ Yes	1/			
	Re	25. Was case referred to medical examiner?			I au		Death (Check only	one)					
	<u> </u>	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of In		utpatient 3 Time of		4 LI Nursin	g Home 5 ☐ Re			cify)			
	0	1 Natural 5 ☐ Pending (Month, E	Day, Year)	Injury	28c. Injur Worl	yat k? Yes 2⊡No	28d. Describe	now injury o	occurrea				
	11Ca	3 Suicide 6 Could not be 28e. Place of In	njury - At home, fa				28f. Location	(Street and	Number or Ru	ral Route Number,			
	Cerr	4 ☐ Homicide determined building, (etc. (Specify)				City or 1	own, State)					
	Medical Certification: 10	29a. Certifier (Check only one) 1 CertifyIng Physician: To the besis and manner and manner on the pasis and the pasis	of examination a	e, death occur nd/or investiga	rred at the til ation, in my o	me, date and plopinion, death o	ace, and due to the	e cause(s) a e, date and p	nd manner as lace, and due	stated. to the cause(s)			
1	Me	29b. Signature and title of perfilings			29c. Licens	e number		29d. Date	signed (Month	n, Day, Year)			
		In pelhere was			1)000	0439	85	MAY	,08,	7008 7008 71201			
		30. Name and address of person who completed cause of	death (Item 23a)	(Type, Print)		215	ST 00	7.22.20	r 121	7/201			
		Sugan J. Duckerian	MD 2	- 2 Sout	H GK	EENE	DAV	IMUK	EIML	101-01			
State istra	-	31. Date filed (Month Day, Year) 32 Regis	trar's Signature	Sporte						,			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		Ce	rtificate of	Death	ı	Reg. No.2	008	15582	
5	Physicia	an	1. Decedent's Name (First, Middle, La Barbara D. Sti					Date of Dea Month	Day	Year	3. Time of Death 9:00 A. M	
100	/Medic		4a. Facility Name (If not institution, giv			4h City Town o	r Location of Death	May	11 4c Col	2008 unty of Death	7.00 A. III	
	Examin	er	1502 Balmoral I			Bel Air	LOGGIOTI OF BOART			ford Cour	ıtv	
The second	Funeral Director		5. Social Security Number 203-10-4684 6. S		yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 3/23/192	h v. Year)	9. Birthp	lace (State or Foreign	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits	
	Marylied at	tor	Maryland Harfo	rd County F	el Air				1 □Yes 2 XNo			
	r 28a r notif	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?	
	23a c ust be		1502 Balmoral D	rive		21014				States		
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14.	Race - Americ Black, White,		
36	irs aft		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Sp	ecify: White	=	
ည်	72 hou natura lical E	Completed by	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind	of Business/Inc	dustry	
2	vithin "ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)		77-4-7			
5	filed v Hygie other i		17. Father's Name (First, Middle, Last	N/A	Mana	ger	18. Mother's Name	(First, Middle,	Hotel Maiden Sui	rname)		
au	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. • marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To Be	George Dougherty				Meta Weekl	ey				
, Maryland 21215-0036	and 2 shou alth and M 27 Is mai er traumal		19a. Informant's Name/Relationship (Code)	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Evans Fune	matory or other place ral chapel	5/12/	2008	Forest	tion - City or To Hill, M	aryland	
Balt	ermit. Departr mporta Iny Inj		21. Signature of Funeral Service Lice	nsee	EV	2. Name and Addre	ess of Facility & C	remation	Servic	es Bel A	ir	
	44 T & 0		23a. Part1. Enter the disease, or comshock, or heart failure. List only	polications that caused the			ve, Forest			21050	Approximate	
	Physician [®]		Immediate Cause (Final							EACE	Approximate Interval Between Onset and Death	
4	/Medical		disease or condition resulting in death)	a. ARTERIDS Due to (or as a co		The chi	KNOVYJC	MCGIA	טטט	-/(30		
	Examiner	<u>_</u>	Sequentially list conditions,	b								
	uted with the state of the stat	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	masquence on.							
ó	rtificate be executed og physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
68760,	ate be hysici the bu	Medical		_ d								
			IF FEMALE:	23c. If yes, outcome pf p	pregnancy				225	d Data of dalis		
P.O. Box	The law requires that the death oe the has been signed by the attendinage 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		230	d. Date of delive Month	Day Year	
	ss that gned b	by Pł	Part II. Other significant conditions	- 1	ot resulting in the u	underlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?	
ord	require	ted		LATION				10	Yes 2 1	No 3 ☐ Prol	bably 4 Onknown	
Records,	e law has b	Completed	HYPERTENSIC					24a. Was auto		24b. Were auto prior to co	opsy findings available ompletion of cause of	
			25. Was case referred to medical	RUCTIVE	PULMON	VARY D	SEASE	1□ Yes	2 No	1 Yes	2 □ No	
Vital	/sicia s certi directo	o Be	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	ent 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho			Other (Speci	(fv)	
JO L	Attending Physician: The lar rideath. cotor: After this certificate has by the funeral director, page 2	n: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time			28d. Describe			97	
Siol	tendli eath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	00	A4 h = = - (-	Yes 2□No	206 1	(0)		10	
Division or	l or At after d Direc	Certification:	4 Homicide determined			treet, factory, office			wn, State)	vumper or Hur	al Route Number,	
_	To the Hospital or Atteni within 24 hours after death To the Funeral Director: completely filled in by the	edical C		hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or i							
	To th withir To th comp	Me	29b. Signature and title of certifier	A 0 - 1	_	29c. Licen:				signed (Month,	Day, Year)	
)	¥		▶ VNV	(10 hyankar	MD		5027		MAY	12	7008	
	6		30. Name and address of person who	completed ause of death HYWKAR 32. Registrar's 3 2008	h (Item 23a) (Type	ORTH A	VENUE	BEL	AR	MS	21014	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1	3 2008 Dec	ear &	Sporte	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9, ŽŽŽDA Mary Jane Schoeberlein /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4c. County of Death Examiner 4b. City, Town, or Location of Death Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Director 94 232-36-3305 01/19/1914 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at Directo Harford Baldwin 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n 2821 Glen Elyn Way 21013 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Esskay Meat Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked oth Be Edith Stewart Gasper M. Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Marshall/ Son 538 Valley View Rd. Towson, MD 21286 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Moreland Memorial 05/14/08 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parkville, MD Park 21. Signature of Funeral Service Licens Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immuliate Cause (Final disease or condition resulting in death) Physician RUPTURED AORTIC ANEURYSM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, ← Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🕱 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

the funeral director.

has

To the Hospital or Attending Physician:

δ Completed

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier

Be 2 Certification:

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No Nown

24a Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No

nt	3 🗆 [OOA	Other:	I ☐ Nursing H	ome	5 ☐ Residence	6 ☐Other (Specify)
of		28c.	Injury at Work?		28d.	Describe how in	jury occurred
	M		1 🗌 Yes	2 □ No			

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c, License numbe

2 □ ER/Outpatie

28b. Time

D25886

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE TOWSON, MARYLAND CEBALLOS. M 7601 OSLER 21204 31. Date filed (Month, Day, Year)

State Registrar

completely

within 2

Medical

MAY 13 2008

5 Pending investigation

6 ☐ Could not be

1 npatient

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12, 2008 12:05 P^M Kathryn Loweree Sanbowers Mav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2058 Bandy Avenue Sykesville Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 218-62-1360 55 AUG 27, 1952 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Sykesville MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 2058 Bandy Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **N**0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Food Service Worker Restaurant s 1 and 2 should be filed wi f Health and Mental Hygier tem 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Edgar **Vincent** Loweree Elizabeth Anderson Knachel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2058 Bandy Avenue Sykesville, MD 21784 Anne L. Davis, sister Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/13/08 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Keo 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Idenocarcio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Duri to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Due to (or as a consequence of) burial-1 P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 2. No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl the Hospital or Attending Physician: The 1 □Yes 2 No 2 🗆 No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending thin 24 hours after deau...

the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fathi. Amir 401 W. Browny Ballmore, MDZ1231 Fathi

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) W **Physician** 1 LUESTER 5:50 a M LIFFORLI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Genesis Long Green If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 11 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs MAR 18 Maryland 65 Director 218-40-4423 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r then "naturel", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No MD Harford White Hall Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21161 4839 Norrisville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White <u>ک</u> 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other then College (1-4or 5+) Technician Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I e marked Delma Wright Charles Clifford Sylvester Porter 19a. Informant's Name/Relationship (Type, Print) friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 end 2 nent of Health a ant: if item 27 is P.O. Box 176, White Hall, MD 21161 Sharyn L. Schneider-Raun -Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Important: if any injury or once. Metro Crematory, Inc. 5/13/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee Steven H. 22. Name and Address of Fagility Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner ISCHEMIC WOUNDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical 88 IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. β 1 Yes 2 No 3 Probably Wunknown cate hes been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? Medical Certification; 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending Injury 1 Yes 2 No death. 2 Accident investigation efter death the 6 ☐ Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours e Conflying Physician: To the best of my knowledge, death oncurred at the time, date and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31136 LU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD BALTIMORE ALLACE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

To the Hospital or Attending Physician: within 24 hours To the Funeral

> Registrar DHMH 17 Rev 1/2001

State

Ph

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

DEEPTI

S. HANOVER

29c. License number

STREET

RES 0001

29d. Date signed (Month, Day, Year)

BALTIMORE

2008

and manner stated

01

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHI

MAY 1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Robert Fr

obert Francis S	1	- For State Certificate of D		yglerie Reg. N	lo. 200	8 1558					
Physicia	ın/	egistrar 1. Decedent's Name (First, Middle,Last) Robert Francis Scus	gol	2. Date of Death Month Da May 10, 2008	у Үеаг	3. Time of Death 2205 hrs					
ledical Examii		4a. Facility Name (if not institution, give street and number) 4b. (City, Town, or Location of Death	Iviay 10, 2000	4c. County of Deat	h					
es s	Щ	oron Early Ophing Tray	olumbia Under 1 Year If Under 24Hrs	8 Date of Birth(M	Howard IM/DD/YYYY) 9. Bi	rthplace (State or					
Funeral Director		218-17-5675 1XM 2F 29 Yrs.	Months Days Hours Min	_	Forei	gn Duntry) Wash.,DC					
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
Maryland 28a-f show d at once.	į.	MD Howard Columbia	× = 0	1100	Citizen of What Cou	1 X Yes 2 No					
n with the Maryland ms 23a or 28a-f sho be notified at once	Director	Toc. Strock and Herrison	0f. Zip Code		.S.A.	and y?					
sath with th items 23a ust be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto	pecify Yes or No-		rican Indian, Black,					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No 9 Unknown g 1 Unknown g 23d. Date of delivery Month Day Year									
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Division To the Hospital or Attenuithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only only 200) Wedical Examiner: On the basis of examination and/or investigation	d at the time, date and place, a n, in my opinion, death occurred	nd due to the cause(d at the time, date ar	s) and manner as s	tated.					
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (
_/\		(Calcust	O.C.M.E.		May 12, 2008						
301		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 21	1201							
	tate	31. Date filed (Month, Day, Year) MAY 1 3 2008 32 Registrar's Signature	20								
Regis		ORIGINAL	==								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 3. Time of Peath 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0 00 B /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and no Examiner BON SECOURS 10 Date of Birth (Month, Day, Year) 07 03 1948 Birthplace (State or Foreign Country) 5. Social Security Number ear 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 215.46.672 12 M 2□F 59 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Counfy ral", or Items 23a or 28a-f show Examiner must be notified at MD Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Falls Gwunns and 2 should be filed within 72 hours after death v teath and Mental Hygiene. m 27 Is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Heath and Mental Hyglene. Internative if them 27 is marked other than "natural", or I amy Injury or other traumatic event, the Medical Examinating the Medical Examination. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Black Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) & Gamble Proctor Engineer 12th arade -years 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Speight Budah Mae Williams Marcellus မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Baltmore MD 21216 Falls Parkway GWYNNS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Gamson 05/16/08 DWINGS Milb, MD forest. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Vaughn Greene Funeral Suco Ustown MD 21132 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a /a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last AMINER Examine CERTIFICATION APPROVED BY ME The law requires that the death certificate be executed burial-trar and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐Unknown 1 ☐ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed certificate 1∐ Yes 2 24 or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 □ No 2 ER/Outpatient 3 OOA P 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner Death Certification: 28c. Injury at Work? 7:39 p.M latural 5 Pending investigation 05/08/2008 Subject choked on bolus of 1 ☐ Yes 2 ☐ No 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Home 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number of City or Town, State) 3131 Gwynns Falls Baltimore, MD 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 13

2008

egistrar's Signature

			For State	State of Maryla				lental Hyg	jiene	1000
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Death	2. Date of Dea	leg. No.	3. Time of Death
П	Physicia	an	FI ORFC	SWAI	1FS			Month Hay	Day Year 12 2008	20 1
and the same	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	r Location of Death	1100	4c. County of Dea	th
أدميد	Examin		Northwest Ho	spital			allstown			MOSE.
	Funeral		5. Social Security Number 6. Sex 218–44–8454 1□	7. Age (In yi	rs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	A	05 113.			1-8-194	3	MD
	yland how		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e Mai	cto	MD Baltimore		lindsor M					1 ☐ Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra injury must be purified and once.	Funeral Director	3508 Langrehr Road			10f. Zip Code 21244			I0g. Citizen of What Co USA	ountry?
	ems 2	ner	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 □XNo If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:	,		ican-American
Maryland 21215-0036	2 hour	ted k	15. Decedent's Educa	ation		dent's Usual Occup		U	16b. Kind of Business	/Industry
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and	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name Helen Art		waiden Surname)	
Ž	2 should and Me is mark aumatic	2	Elmer Wilson 19a. Informant's Name/Relationship (Typ	e. Print)	19b. Maili	na Address (Street			r, City or Town, State,	Zip Code)
	and 2 s lealth ar m 27 is her trau		Maurice Wood/Son	<i>,</i>		•	ed, Windsor			•
altimore,	of He of He fitem		20a. Method of Disposition	20b	Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State
<u>Ĕ</u>	Pages Iment of tant: If it		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	inioval from state	Barrison 1	Forest Vete	rans 5-20-(Owings Mills	
Ball	permit. Pag Department Important: I any intury c		21. Signature of Funeral Service L. enser	10 (h de)			ss of Facility Wy <u>lf</u> Road,Randa		Hame P.A. o. MD 21133	f Balto Co.
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- April	Physician		Immediate Cause (Final disease or condition	4 400	Tage	COPD.				Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
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ta	an: The		25. Was case referred to medical				26. Place of Deat	1 □Yes	2 2 No 1 □ Ye	s 22No
<u> </u>	ysicia iis cer direct	o Be	examiner?	ospital:	☐ ER/Outpatie	ent 3 DOA Oth	or:	··	lence 6 Other (Sp	ecify)
Division of Vital Records, P.O. Box	Attending Physician: The law sr death. ector: After this certificate has by the funeral director, page 2 g	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	Wor	ry at k? !Yes 2 □ No	28d. Describe h	now injury occurred	
isi	l or Attencafter death Director:	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, st		res ZLINO		Street and Number or F	Rural Route Number,
<u>S</u>	s after s after al Dire	Certi	4 ☐ Homicide determined	building, etc. '(Spe	ecify)			City or Tow	/n, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical (ician: To the best of my ler: On the basis of examend manner stated.						
	To the within To the compl	Me	29b. Signature and title of certifier	· U7		29c. Licens			29d. Date signed (Mor	
			+ Fighour	- ,112	00 \ /T	1 3	5843		May 12	2008
	5		30. Name and address of person who con Abdallah Kafrou	NI 5401	Old (Pourt Ro	ad , Ra	ndallst	town, HI	0 21133
Jan.	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 3 2008	32 Registrar's Sig	gnature	uli				
			Pant on the Ch. manage	1-00	6.5					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 7:56 pm William Henry Salter, Jr. 9, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Owings Mills 9725 Lyons Mill Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) pril 3, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Months Min. 93 1**X** M 2 ☐ F Maryland 1915 216-10-1548 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Owings Mills Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21117 9725 Lyons Mill Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Seaman William Henry Salter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9725 Lyons Mill Rd., Owings Mills, Md. 21117 Thomas Hardy - Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State May 14, 2008 Pikesville, Md. Druid Ridge Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 21. Signatur f unera Service Licensee 21117 11605 Reisterstown Rd., Owings Mills, Md. Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cacheria disease or condition resulting in death) Due to (or as a consequence of): Brown Tumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probabiy 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【XNo 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 27. Manner of at 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No M

Physician /Medical Examiner the death certificate be executed

Physician /Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or herman any Injury or other trainment.

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Division or Vital Records, P.O. Box 68760,

lospital or Attending I hours after death. within 24 hours after ucc....

To the Funeral Director; Aft Hospital Medical the Registrar

Physician/Medical Examiner þ Completed Be P Certification:

> 31. Date filed (Month, Day, Year) State 1

3 Suicide 4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Suite 205. 5400 OLD COUNT

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21133

			1 - For State Registrar	State of Maryla			nt of H te of L			iene	008	15591
	Di		1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Day	Yeer	3. Time of Death
	Physici /Medic		Virginia Marie	Shipley					May	12	2008	9:35 a M
tr	Examin		4a. Facility Name (If not institution, give st.	reet and number)				Location of Death	1		ounty of Death	
			Longview Nursin			1	anche er 1 Year	ester If Under 24 Hrs.	O Date of Birth		arroll	
	Funeral		5. Social Security Number 6. Sex	M 2 F 88	s. last birthday) Yrs.	Months		Hours Min.	(Month, Day,	Year)	Cot	nplace (State or Foreign untry) aryland
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	yland		10a. State 10b. County		City, Town or Lo							10d. Inside City Limits
	B-f-B	ctor	Maryland Carrol	.1	Hamps	tead	d —————					1 □Yes 2 □No
	or 28	Olre	10e. Street and Number			10f. Z	ip Code		11	0g. Citize	n of What Co	untry?
	ath w	Funeral Director	3530 Basler Rd.				2107				.S.A.	
	er de Itam	nue	TI, Waltar States	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14	. Race - Amer Black, White	
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Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Winter or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show imatic event, the Madical Examiner must be notified at	ted	15. Decedent's Educa		16a. Dece	dent's Us	ual Occupa	ation		16b. Kind	of Business/I	Industry
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בו	ould be fited v I Mental Hygie varked other t vatic svant, th	Be	17. Father's Name (First, Middle, Last) Carmello Lana						ne (First, Middle, M		umame)	
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<u>a</u>	d 2 st th and th and traun		19a. Informant's Name/Relationship (Type Carroll A. Shir	", F'''''' Husban	d 3530				stead, M	-		
ō,	permit. Pages I and 2 should be Deperment of Health and Mental Important: If item 27 is marked any injury or other traumatic av once.	1 8	20a. Method of Disposition	1 e y	. Place of Dispo						ation - City or	
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=	ertm Sertm Injur		21. Sunature of Funer 15 rvice lice	3	Colorador (Marchael Colored Statement of project (1996)		-		hapel, P		ALD VIII	c, naryrana
m			Fram JOMain	1.	3	296	rat r Charm	il Drive	Manche	.A. ster	, Maryl	land 21102
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	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
	LAGIIIIIICI	_	Sequentially list conditions, b.	Due to (or as a cons	2009	KH2	MY	2				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equatica or).							
	execu n and al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a cons	equence of):	_					-	
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	call	d.									
89	tificat ng phy as th											
ŏ	ith cei tendir or use	an/h	230. Was decedent pregnant	ic. If yes, outcome of pred 1 Live birth 2 ☐ F		□Ectopic	pregnancy			23	d. Date of deli Month	ivery Day Year
	e dea the at ned fo	sici	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown	fdeath 5	Other (specify)				WORLD	Day Total
<u>.</u>	hat th od by detacl	by Physician/Med	Part II. Other significant conditions cont	ributing to death but not	resulting in the	underlying	cause civi	an in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
ds,	8 6 9					,			1 🗆 Y	es 2)	No 3□Pr	obably 4 Unknown
Ö	w requir been si should I	Completed							24a. Was a	ın	24b. Were au	itopsy findings available
Re	he lav e has age 2	шo							autops perfor		prior to death?	completion of cause of
ta	en:] tifficel tor. p	a)	25. Was case referred to medical					26. Place of De	1 ☐ Yes : ath (Check only on	4	10 163	24410
>	nysici direce	To B	examiner? 1 ☐ Yes 2 💢 No	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3□ I	Oth	er: 4 Nursing H	lome 5□ Reside	ence 6	☐Other (Spe	cify)
0	ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury		28c. Injury World	k?	28d. Describe he	ow injury	occurred	
<u>s</u>	tendi leath. tor: A the fa	cati	2 Accident investigation 3 Suicide 6 Could not be			M		Yes 2 □ No	286 Lanation (C		Mumbos os Di	red Courte Alumbas
	or Atter catter of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe		treet, tact	ory, office		City or Town		Number or At	ural Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifying Physi	ician: To the best of my	knowledge, dea	th occurre	ed at the tin	ne, date and place	e, and due to the c	ause(s) a	and manner as	s stated.
	Metely	Medicai	(Check only 2 Medical Examin one)	er: On the basis of exam and manner stated.	ination and/or in	nvestigati	on, in my o	pinion, death occi	urred at the time, d	late and p	place, and due	to the cause(s)
	To the Hospital or Atlanding Physicien: The Is within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page:	W	29b. Signature and title of certifier	SALA MAY	Y	2	9c. Licens				signed (Mont	
1	~		· Californian	Minaria			DI	2110	5	,	-15 -	08
2	•		30. Name and address of person who cor	mpleted cause of death (tem 23a) (Type	, Print)	200	ret	etmin	ata	7 29	nd alls 7
)		31. Date filed (Month, Day, Year)	32 Aegistrar's Si	nature	ain) UK	1146	CO (TIME)	10,		
	Sta Registi		MAY 13 200	18 2000	D. A.	234/2	Refer to the second					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

XXYes 2 □ No

Maryland

14. Bace - American Indian

White

Inc. 21211

Approximate Interval Between Quset and Death

ears

Year

24b. Were autopsy findings available prior to completion of cause of

death? 1 ☐ Yes 2 ☐ No

Black, White, etc.

23d. Date of delivery

Month

200 gar

4c. County of Death

USA

5:15 PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37 Registrar's Signature

17 ISABELIE 31. Date filed (Month, Day, Year)

MAY 1 3 2008

DHMH 17 Rev 1/2001

Registrar

DAGREGOR, 700 W. 40th STREET, BALTIMORE, DD 21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2008 **SCHWARTZ** 10 3:50A [™] HENRY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON 9. Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. Date of Birth Month Day Year) 12/23/1921 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours Months MD 216-16-0617 86 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 1 □Yes 2 No BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21208 USA 4525 TAPSCOTT ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PHARMACIST PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) WOLF **SCHWARTZ** MARY **ISAAC** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4525 TAPSCOTT ROAD, PIKESVILLE, MD 21208 GOLDIE SCHWARTZ / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State 05/11/ 2008 BALTIMORE, MD SHAAREI ZION CONG. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility INC. 21208 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Mat Cen 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARICINSONS trs. disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pneu monia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

"natural", or items 23a or 28a-f show idical Examinar must be notified at

Funeral Director

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Be Completed

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Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

th and Mental Hygiene.

7 is marked other than "natur traumatic event, Its Wedlest.

27

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

3altimore, Maryland 21215-0036

be executed and burial-1 attending physician for use as the burial signed by Records,

Box 68760,

P.O.

Division of Vital

Hospital or Attending

death.

n 24 hours after death.

Re Funeral Director: A

pletely filled in by the fu

within 2.

completely

icate has been siç , page 2 should b certificate director, this After this funeral of

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown þ Completed 25. Was case referred to medica examiner? Be examiner? 1 ☐ Yes 2 X No Hospital: 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident

autopsy 1 □Yes 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence Of Other (Specify)

28d. Describe how injury occurred

Balto MD

1 ☐ Yes 2 ☐ No

5 Pending investigation

6 ☐ Could not be

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

Medical

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

29b. Signature and title of certifier

32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

08-Cha

adolible Ink Ensure All Copies Are Legible.

03364		Please Type or Print in Black Indelible Ink. State of Maryland / Department of He	ealth and Mental Hygi	iene	•
arles Smithell	1-	- For State Control of Department of The	eath	Reg. No	0. 2000 155
Dhyminia	R	legistrar 1. Decedent's Name (First, Middle,Last)	2.	Date of Death Month Day	3. Time of Death U
Physicia edical Examir		Charles Smithell		May 2, 2008	22491115
ed.	4	4a. Facility Name (if not institution, give street	City, Town, or Location of Death	1	4c. County of Death
(Johns Hopkins Bayview	altimore Under 1 Year If Under 24Hrs. 8	B. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or Foreign
Funeral	5	5. Social Security Number unk	tenths Days Hours Min		Country) UIIK
Director	_L	1XM 2F 76 Yrs.		Jan 1, 1	
ý		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location			10d. Inside City Limits
d how a	_	MD Baltimor	:e		1 X Yes 2 No
arylan 8a-f s	Director	10e. Street and Number	of. Zip Code	10g. C	Citizen of What Country?
death with the Maryland or items 23a or 28a-f show any must be notified at once.		483 Mirabile Lane	21224	'C Man on No	USA 14. Race - American Indian, Black,
n with	era	Armed Forces?	ecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto Ri	can, etc.)	White, etc.
r death	Funeral	1 Yes 2 X No	es 2 X No specify:		Specify: white
rs after ural", miner	۵	or Dates:	Usual Occupation (Give kind of wor		b. Kind of Business/Industry unk
2 hour "natt	좕	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retired	3)	
336 thin 7 ne. than	ompleted	unk unk	unk 18.Mother's Name (I	The Asiatio Asolo	den Surname) unk
215-0036 be filed within 72 hour ntal Hygiene. rked other than "natt ent, the Medical Exa	S	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (-irst, Middle, Mait	ulik ulik
be f	o Be	19a. Informant's Name/Relationship (Type, Print)	ddress (Street and Number or Ru	ral Route Numbe	r, City or Town, State, Zip Code)
MD 21 d 2 should lth and Me n 27 is ma aumatic ev	۲	13a. Illiottiants Hamortosations (1)	astern Avenue Ba	altimore	, MD 21224
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If titem 27 is ma injury or other traumatic ex		20a Method of Disposition 20b. Place of Disposition	on (Name of cemetery,	Date 2	Oc. Location - City or Town, State
DOFE ages 1 at of F t: If i	l	1 Burial 2 Cremation 3 Removal from State	pieco,		
Baltimore, permit. Pages 1 at Department of Ho: Important: If ite injury or other tr	-	4 Donalton 5 X Other Specify: in state 21. Signature of Funeral Service Licensee Ronald S Made Director Sta	me and Address of Facility	d 655 W.	Baltimore Street
Dep Derr inje		Ronald S Wedt Director Sta	timore, MD 2120	1	Baltimore Street
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		respiratory arrest	Between Onset and Death
/Medical aminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiov Due to (or as a consequence of):	vascular Disease		
		, b			
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit		d. **			
e exec cian ai rial - t	dical	UNPENDED AMENDED			
OX 68760, rath certificate be executed attending physician and for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Feta	al death 3 Ectopic pregna	ncy	23d. Date of delivery Month Day Year
68 certifi nding ise as	cian	past 12 months? Control Control	er (Specify)		
Box e death the atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown	i and Barki	1230 Did tob	acco use contribute to the cause of death?
O. O. Box that the deatl ned by the att detached for	by P		iderlying cause given in Part I.		2 No 3 Probably 4 ✔ Unknown
S, P.C nires that n signed d be deta	pa pa			24a. Was ar	24b. Were autopsy findings available
ords, P w requires t as been sign should be	Completed			autops: perforn	ned? death?
Recc The lay cate ha	E O		and Division of Breath (Charles	1 Yes 2	✓ No 1 Yes 2 No
tal Rection: The certificate ector, page	Be		26,Place of Death (Check 3 DOA Other, Nursin		Residence 6 Other:
f Vit Physic er this	ူ	1 Ves 2 No 28a. Date of Injury 28b. Time of In	<u> </u>		ow injury occurred
on of oding Pt. th. : After e funeral	ļ ë	1 Natural 5 Pending	1 Yes 2 No		
IVISION or Attend after death. Director:	ig	2 Accident Investigation 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rural Route Number, City ate)
Div ital or ars after	Certification:	3 Suicide Could not be determined (Specify)			
Hosp 24 hou Fune	a C		red at the time, date and place, and	d due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The Hospital Director: After this certificate has been signed by the attending physici promoted with the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
->	Ž	29b. Signature and title of certifier	O.C.M.E.		May 3, 2008
		CMULD Company of death (from 22s)			
	1	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 2120)1	
		24 Date Stady Meeting Day Yourhand Registrar's Signature			

Registrar

		For		State of Ma	aryland						1ental Hy	giene)		
	_	- State Registrar			*	Cer	tificate	e of L	Deati	h		Reg. No	201	70	15595
Physicia		Decedent's Nam	ne (First, Middle	, Last)		91	WT	1111	1/		2. Date of De Month	eath Day	y Y	ear	3. Time of Death
/Medica	al -		DUI	110		01					MAY			008	7:34PM
Examine	er	4a. Facility Name (, give street and number) DUNS HOPKIN	SUNCO	1741	4b. City,	10wn, or		n of Death	CITU	40.	County of	Death	
Funeral		5. Social Security I			e (In yrs. lasi		If Under	1 Year		er 24 Hrs.	8. Date of Bi	rth	9	. Birthpla	ace (State or Foreign
Director		216-48-	1508	1 ∑ M 2□F	61	Yrs.	Months	Days	Hours	Min.	Nov 9,	1^{Year}	6	Mary	land
ם ,		Usual Residence of	of Decedent												
arylaı show d at	_	10a. State	10b. County		10c. City, T									10	od, Inside City Limits 1 ⊊Yes 2 □ No
the M	Director	MD 10e. Street and Nu	Imbor		Ва	altimo	ore 10f. Zip	Code				10a Cit	izen of Wh	ot Count	Λ
with a or the r				rn Parkway			тот. 2.тр		214			Tog. Oil	US		y:
ns 23	Funeral	11. Marital Status	NOT CHE	12. Was Decedent I	Ever in U.S.	13. V	Vas Deced	ent of Hi	spanic (Origin? (Sp	ecify Yes or No	0-	14. Race -	Ámerica	
0 0 0	by Fur	1 Never Mar	rried 2 Marri	Armed Forces? ed 1 2 Yes 2 1 If Yes, Give Year or Dates:			fYes,speo I∐Yes 2		n, Mexic Specii		Rićan, etc.)		Black, Specify:	White, e	
72 hou "natura dical E	eted		15. Decedent			16a. Deced	lent's Usua kind of wor	l Occupa	ation Juring m	ost of work	ing	16b. K	ind of Busi	ness/Indi	ustry
d within giene. er than	Completed	Elementary/Sec 11	ondary (0-12)	College (1-4or 5	i+)		spers					hyd	lrauli	lc e	quipment
be file tal Hy d othe	Be	17. Father's Name		•							e (First, Middle	-	Surname)		
ould Men	e .		Santhin								Garlo				
and 2 sh ealth and n 27 is n		19a. Informant's N Michele		n/sister			_				al Route Numb wings N			ate, Zip (211	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.			Cremation	3□Removal from State Decify) in state	cem	e of Dispo netery, cren	sition (Nan natory or o	ne of ther place	e)		Date	20c. Lo	ocation - Ci	ty or Tov	vn, State
permit. Departn Importa any inju		21. Signature of F	uneral Service I		•	8	Name an	Anat	tomy	Boar	d 655 I	W. Ba	altimo	ore :	Street
100		23a, Part1. Enter	the dilease, or	complications that caused only one cause on each lir	the death. I					212 as cardiac		arrest,			Approximate Interval Between
Physician		Immediate Cause	(Final	ho	MM	tisc	16								Onset and Death 25 minutes
/Medical		resulting in death)		a. Due to (or as	a cons quen	ice =1:	-								_
Examiner		Sequentially list or	onditions,	b. Dul	monk	FSW	h	eme	rety	age	1			2	5 minutes
pe sit	Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event)	mmediate lerlying	Due to (or as	a consequen	ice of):				J					
cate be executed physician and the burial-transit	хап	that initiated event resulting in death)	ts Last	c Due to (or as	a consequen	ice of):									
						,									
	edical			d											
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months? □ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pro Other (sp						23d. Date (Montl		ry Day Year
that ned by deta	Y P	Part II. Other sign	ificant conditio	ns contributing to death be	ut not resultir	ng in the ur	nderlying ca	ause give	en in Par	rt I.	23e. Did	tobacco (use contrib	ute to the	e cause of death?
w requires been sign should be	D D	(JORTI	C cureu	R.USI	n					1 🗆	Yes 2	□ No 3	☐ Proba	ably 4 Wiknown
aw re	Completed				U						24a. Was	s an	24b. We	ere autop	sy findings available
The la	E											ormed? 2 \Begin{array}{c} No	de	ath?	pletion of cause of
sician: Th certificate rector, pag	Re	25. Was case refe examiner?	erred to predical							ice of Deat	h (Check only				
hyste this co	<u> </u>	1 □ Yes 2		Hospital:		/Outpatien			4 🗆		me 5 Res)
iding Phys h. After this funeral dir	<u>.</u>	27. Manner of Dea 1 D Natural	5 Pending		ry 28 y Year)	3b. Time of Injury	M 2	Bc. Injury Work			28d. Describe	how inju	ry occurred	l	
death ctor: / the	cat	2 ☐ Accident 3 ☐ Suicide	investig 6 ☐ Could n	ot be 290 Place of init	ury - At home	e farm stre			Yes 2		28f Location	(Street ar	nd Number	or Rural	Route Number,
s after al Dire	Certification:	4 Homicide	determi	building, etc	c.'(Specify)			,			City or To	wn, State	9)	or riara	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical €	g Physician: To the best of Examiner: On the basis of and manner sta	f examinatior	edge, death n and/or inv	occurred vestigation	at the tim in my o	ne, date pinion, d	and place, death occur	and due to the red at the time	e cause(s e, date an) and manr d place, an	ner as sta d due to	ated. the cause(s)
To t withi To t	Σ	29b. Signature and	d title of contifier	John	<u></u>	- M	290	. License		00	00	n1	te signed (200
		30. Name and add	ACIE	who completed cause of d	eath (Item 23			00	NI	wolfe	St	BALT	INNOF	ms	1 21287
State Registra		31. Date filed (Mo.			ar's Signatur	е	alls)		- 70/1			- 1-1	7/1000	1150	, 0 ,
riogiotia			т я	LOUG JUBBLE	US	MO			_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Seese 1618 **Physician** Charles W. 9 05 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Harbor Hospita If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 218–36–0776 Age (In yrs. last birthday) **Funeral** Months 1XIM 2□ F 68 10/24/1939 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, th. M. dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XXes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 1731 Light Street USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Merchan 11. Marital Status 1 Never Married 2 Married White Maryland 21215-0036 If Yes, Give Merchant Year or Dates: Marine 1 ☐ Yes 2 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stevadore Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray Jackson Seese Sr. Lillian Maude Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Rae Marshall / Sister 1731 Light Street, Baltimore, MD 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/13/2008 Bayview Crematory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licence Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** sere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, physician at the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a. Was an certificate 1□ Yes Division or Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient P 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manne of Death 1 Natural Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) no manner stated. 29c. License number 29b. Signature and title 400064990

ys.

State Registrar

DHMH 17 Rev 1/2001

S. HanoverSt. Baltimore MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 l 5 32. Registrar's Signature

Scherago

MAY 1 3 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month :50 PM 2008 orence /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner enter owson ear | If Under 24 Hrs. | If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🛈 F 32-46-06/6 Aug 4, Yrs. Director WestVirginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, it is leaded Exercise must be notified at 1 ☐ Yes 2 🔼 No Director Saltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3020 2105 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 ₩Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is and 2 should be filed within the Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) A&P Grocer Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Nora 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Arm Dudley 13020 Manor Rd Maryland 21057 permit. Pages 1 and Department of Heall Important; If item 2: any injury or other t laylor Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cometery 5/12/08 4 ☐ Donation 5 ☐ Other (Specify))altimore 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel + Cremation Services 18800 Harford Road Parkville mb 2123 Parkville mb 21234 lai Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ADVANCED MONTHS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner certificate be executed Box 68760, sician and burial-trans Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| C | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MO 21204 DANIENE DEBERMAN, MD N CHAPLES ST, SUITE 209 6565 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Malers. MAY 13 Registrar

	I- For State Certi	tment of Health and Mental H ficate of Death	ygiene Reg. No. 200	8 559							
Physician/ Medical Examiner	Accistrar 1. Decedent's Name (First, Middle,Last) William James Tracey, Jr.		2. Date of Death Month Day Year May 11, 2008	3. Time of Death 1335 hrs							
Paris L	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Taneytown									
Funeral Director	306 East Baltimore Street 5. Social Security Number 212–06–4591 6. Sex 7. Age (In yrs. last		. 8. Date of Birth(MM/DD/YYYY) 9. Birt	hplace (State or n untry) MD •							
d how any	Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location eytown		10d. Inside City Limits 1 X Yes 2 No							
the Maryland a or 28a-f sh <u>tified at onco</u>	10e. Street and Number 306 East Baltimore St.	10f. Zip Code 21787	10g. Citizen of What Cour	ntry?							
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 15. Decedent's Education (Specify only highest grade completed)	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref	Rican, etc.) White, etc. Specify: Whi work done 16b. Kind of Business/								
21215-0036 old be filed within 72 hour Mental Hygiene. marked other than "natu c event, th. Medical Exam To Be Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 There's Name (First, Middle, Last)	Manager 18. Mother's Nam	Food Serv e (First, Middle, Maiden Surname) Marie Banghart	rice							
MD 21218 dd 2 should be fili dd 2 should be fili ma 7 is marked I aumatic event, t	William James Tracey, Sr. 19a. Informant's Name/Relationship (Type, Print) Donna M. Tracey - mother	19b. Mailing Address (Street and Number or 4484 Woodsman Dr. #1	Rural Route Number, City or Town, State	e, Zip Code) 21074							
Baltimore, Noemit Pages I and 2 Department of Health Important: If item injury or other trau	1 Burial 2 X Cremation 3 Removal from State Metr 4 Donation 5 Other Specify:		Date 20c. Location - City or y 15,2008 Baltimor	ce, MD.							
	21. Signature of Funeral Service Licensee J. Hald Lelah 23a. Part I. Enter the disease, or complications that caused the death. I		chardt Funeral Char Manchester, MD. 21	P.A. 102							
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of)			Between Onset and Death							
ted Insit Examiner	b. Due to (or as a consequence of): Due to (or as a consequence of):										
0, e be executed ysician and burial - transit	d.										
60, ate be execu hysician anc te burial - tra	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregn	ancy	23d. Date of delive	•							
Box 6876(ne death certificate the attending physoric for use as the bry Sician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic pregrath 5 Other (Specify)		Day Year							
P.O. Bc s that the deagrand by the a e detached fa by Phys	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	party							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical E			autopsy prior to performed? death?	autopsy findings available completion of cause of							
tal Rection: The certificate ector, page	25. Was case referred to medical examiner? Hospital:	26.Place of Death (Chec		au Caana							
n of Vi ding Physi After this funeral dir on: To	1 Yes 2 No 27. Manner of Death 28a. Date of Injury(Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	ing Home 5 Residence 6 • Oth 28d. Describe how injury occurred Subject asphyxiated	er. ocene							
Division o spital or Attending nours after death. refilled in by the func Certification:	2 Accident Investigation May 11, 2008 3 Suicide 6 Could not be determined (Specify) Home	FOUND: 1 Yes 2 No 1320 hrs 1 Yes 2 No	28f. Location (Street and Number or F or Town, State) 306 East Baltimore Street, Taney								
Division To the Hospital or Attent within 24 bours after death To the Funeral Director: completely filled in by the	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.	ge, death occurred at the time, date and place, a ad/or investigation, in my opinion, death occurred	nd due to the cause(s) and manner as st	ated.							
To Con Mee	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (May 12, 2008	29d. Date signed (Month, Day, Year) May 12, 2008							
	30. Name and address of person who completed cause of death (Item Donna M. Vincenti, MD Assistant Medical Exam		MD 21201								
State Registra	31. Date file (Month, Pay Year) 18 32. Registrar's Signatu										

			State of Maryland / Depa	rtment of Health and N <i>tificate of Death</i>				
			1. Decedent's Name (First, Middle, Last)	lilicate of Death	Reg. N	No. 2. 0 0 3. Time of Death 9		
	Physici /Medic		Elizabeth Tull		<u> </u>	2008 Year 10:20 A M		
	Examin		4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death Timonium	4	4c. County of Death Baltimore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea			
	Director		047-05-8195 1□M 2図 F 93 Yrs.	Months Days Hours Min.	Jan. 16,	1915 Maryland		
	and		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits		
	Maryli -f sho	tor	MD Wicomico Salisbur	V		1 □Yes 2X No		
	h the or 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	23a c		705 Alvin Ave.	21 804	US			
1.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with highly or other traumatic event, the Medical Examination is not made.	by Funeral	1 Never Married 2 Married 1 TYes 2 X No	Vas Decedent of Hispanic Origin? (St Yes, specify Cuban, Mexican, Puerto Yes 2X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
a.m.	72 hou natura	event, the Mudical E. Be Completed	15 Decedent's Education 16a, Deced	lent's Usual Occupation kind of work done during most of work OO NOT use retired)	ting 16b.	. Kind of Business/Industry		
:20	within lene. than '		Elementary/Secondary (0-12) College (1-4or 5+)	uselor		ducation		
	of filed other		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid			
~ 10	should be and Mental s marked o	To E	Harry B. Coulbourn		onstance	Reid		
2008 10 Maryland	d 2 shoth and the and 7 is mutaum			g Address (Street and Number or Ru Burleigh Road, L				
	s 1 and f Health item 27		20a. Method of Disposition 20b. Place of Dispo			. Location - City or Town, State		
11	Pages nent of I int: If ite		4 □ Donation 5 □ Other (Specify) Hilltop S	vc.Corp. 05/13		Towson, Maryland		
MAY 11,	permit. Departr Importa any Injt			Name and Address of Facility Ru 50 York Road, Tou		Funeral Home, Inc. Land 21204		
	Physician /Medical Examiner	miner	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR AC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury)			Interval Between Onset and Death		
903583 VOB (death certificate be executed the attending physician and for use as the burlal-transit	Physician/Medical Examine	1 ☐ Yes 2 X No 4 ☐ Pregnant at time of death 5 ☐	□Ectopic pregnancy □Other (specify)		23d. Date of delivery Month Day Year		
TULL	s that the	ρ	9 ☐ Unknown Section Part II. Other significant conditions contributing to death but not resulting in the u		d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown			
ELIZABETH T	The ate h	Completed			24a. Was an autopsy performed 1 □ Yes 2 X			
LIZA	Physician: The Physician: The Physician: The Physician of	Be	25. Was case referred to medical examiner? Hospital:		th (Check only one)	a May (a. (b. HOCDICE		
	2 4 in the second	on: To	1 ☐ Yes 2 ☒ No ☐ HOSPITAL 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 1 ☒ Natural 5 ☐ Pending (Month, Day, Year) 1 ☒ Natural 5 ☐ Pending	f 28c. Injury at Work?	at 28d. Describe how injury occurred			
	or Atter in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stress building, etc. (Specify)	M 1 □Yes 2 □ No eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)		
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spread.					
	To the within To the Compl	Me	29b. Signature and title of certifier	29c. License number DSZ 7	40 P	Date signed (Month, Day, Year) Way 2 2005		
	P		30. Name and address of person who completed cause of death (Item 28a) (Type, Print)					
		ate	DR. ERNESTINE WRIGHT 2300 DULANEY V 31. Date filed (Month, Day, Year) 32. Degistrar's Signature	ALLEY RD. TIMON	UM, MD 210	U Y 3		
	Regist	ate rar		aute)				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 11, 2008 6:55 P M May Richard Tarantola Peter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Towson 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F Months Days 1950 58 Director 080**-**42-6509 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Redical Evenning mast be a callified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 💢 💢 o Directo Lutherville Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 U.S.A. 102 Belmore Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Divisional Director <u>Administration</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Diego Tarantola Margaret Bertolini မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 Jennie Tarantola Wife 102 Belmore Road 20b. Place of Disposition (Name of Duraney Valley Name of Duraney Valley Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-16-2008 Timonium Maryland 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 thou 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final renx(CANCER **Physician** 10 ars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) .
The law requires that the death certificate be executed Exami Due to (or as a consequence of) Box 68760 Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Vital 1 🗌 Yes e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certificalety filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖰 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 12, 200 F 25205 uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N-Chulos St. Balto Mil 2020x Rilay 6701 31. Date filed (Month, Day, Year)
MAY 1 3 2008 3 Registrar's Signature State

Registrar

amend items 17, 18 per fh 8879 5-16-08 vt. State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 💪 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 8 **Physician** NGRAM 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner COUNTY GEN. HOWARD OLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 26, 1944 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 4-46-0556 Months 1 □ M 2 K F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hygiene. "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Directo MARYLAND HOWAR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If them 27 is marked other thu any Injury or other traumatic event the KIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Ingram Be Lee Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PREDERICK M. TILLMAN (HUSBAND **FOOTED** 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation CREMATORY 05-19 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician WEEK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed STAGE and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 🗹 Unknown 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?∕ 1□ Yes 2 No this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗹 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Mannet of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDARLANE COLUMBIA HD. 21044 Year) 13 State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 Mai /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner tora adonna Heritage If Under 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 248-34-4604 Hours Min. 1 □ M 2 F Months Davs Director looth Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, if a Medical Expression must be rotified at Completed by Funeral Director cretts 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes Specify. 3 ₩ Widowed 4 Divorced Whit Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RANKlin a 17. Father's Name (First, Middle, Last) 18. Moţher's Name (First, Middle, Maiden Surname, Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Ploute Number, City or Town, State, Zip Code) Pages 1: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Orest 22. Name and Address of Facility 3 New Port 21. Signature of Funeral Service Ligensee 23a. Par I. Enter the dis 15 or complic flons that caused II death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only in cause on each life. Immediate Cause (Final disease or condition resulting in death)

a.

A IZC here:

Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 1 Yes 24a. Was an autopsy 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A 2 Accident 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

MO rettsville 20c. Location - City or Town, State ALL rures + 1411, 40 21050 Approximate Interval Between Onset and Death 12645 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2120

10d. Inside City Limits

1 □Yes 2 No

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Klousz

MAY 1

X 10-252

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Charles

32. Reastrar's Signature

DHMH 17 Rev 1/2001

29c. License number

1 3/2 95

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		Registrar	Ce	ertificate of	Death		Reg. No.	<u> </u>	
Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Wanda M. Weber				2. Date of De Month	Day Year	3. Time of Death O6: OA M	
Examin Funeral		5. Social Security Number 6. Sex 7. A	altimore ge (In yrs. last birthda	Baltim	r Location of Death ore City If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	4c. County of Dear	thplace (State or Foreign buntry)	
Director		218-05-4147 Usual Residence of Decedent	89 Yrs.			Jan 28	8, 1919 Ma	ryland	
//arylar f show	jo	10a. State 10b. County	10c. City, Town or i					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
th the l	Director	Maryland Baltimore 10e. Street and Number	WILIGS	or Mill 10f. Zip Code			10g. Citizen of What Co	puntry?	
s 23a	eral [1702 Fairbrook Court		21244			USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Evanitment has notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	(No I	3. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 Ϊ No	Ilspanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	o- 14. Race - Ame Black, Whit Specify: Whi	e, etc.	
ilthin 72 ho ne. han "natur e Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Giv	cedent's Usual Occup ve kind of work done v. DO NOT use retire Les	durina most of worki	ing	16b. Kind of Business	·	
filed w Hygie other ti		17. Father's Name (First, Middle, Last)	Ja.	res	18. Mother's Name	e (First, Middle	Department	Store	
uld be Mental Irked c	To Be	Harry Lehnhoff			Mabel S	Smith			
12 sho h and I ris ma trauma		19a. Informant's Name/Relationship (Type. Print)					per, City or Town, State, .		
Pages 1 and nent of Health int; If item 27 iry or other to		John H. Weber, Husband 20a. Method of Disposition		Falrbrook position (Name of rematory or other place		ndsor (Mill, Maryla		
Pages nent of ant; If i		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	:	rematory or other plac rematory]	i .	2/08	Baltimore	. Marvland	
permit. Departr Imports any inju		21. Signature of Funeral Service Licensee Thomas Gregor		22 Name and Addre Cremation 299 Frede	ss of Facility Society crick Road	Of Mary Baltin	yland, Inc.	and 21228	
Physician /Medical		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	ercapa	ic Resp	piraton	Fai	lure	Approximate Interval Between Onset and Death	
icate be executed by physician and interpretation in the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	Physician/Medical		2 Fetal death 3	B ☐ Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year	
w requires that been signed b should be deta	þ						tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
25	Completed	aut per				24a. Was auto perfo 1 □ Yes			
sician: The certificate irector, pag	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)							
g Phy ter this neral di	n: To	27. Manner of Death 28a. Date of Inj	ury 28b. Time	of 28c. Inju	4 Li Nursing Ho		dence 6 ☐ Other (Spe how injury occurred	ecify)	
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	1 Matural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation 3 □ Suicide 6 □ Could not be determined determined 4 □ Homicide (Month, Day, Year) Injury Work? 1 □ Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C								
Withi Comp	M	29b. Signature anglittle of Certifier	ч0.	29c. Licens	e number		29d. Date signed (Mont	h, Day, Year) 2008	
		30. Name and address of person who completed cause of MALKOS KASHIOUR (5, MD \$	death (Item 23a) (Type INAL Hos	eital of	Baltimo	e			
Stat Registra		31. Date filed (Month, Day, Year) 32. Regist MAY 1 3 2008	rar's Signature	Gorale					
MH 17 Roy 1/20)() t	MINI T II CONT	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician COA M /Medical 4c. County of Death City Town, or Location of Death **Examiner** 9. Birthplace (State or Foreign If Under Year 8. Date of Birth **Funeral** Months Days Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, I'm madical Ever, inc. 1 ust be rediffed at 1 Z es 2 No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ofton Funeral . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No \$ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, The Man Elementary/Secondary (0-12) College (1-4or 5+) 's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number of Informant's Name/Relationship (Type. Print) Baltimore, Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition

Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (A Pages 1 Owings Mills, MD 21. Signature of Funeral Service License arefu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncuritying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 X No Dav 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown HAZEL WINSTON 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown funeral director, page 2 should Completed been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an certificate has autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 8 \(\text{Other} \) (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signatue and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERENSTINE WRIGHT 2300 DULANEK VALLEY RD. TIMONIUM, MD 21093 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILKINS ARLOTTA MA 8:00 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5352 Old Stone Court Columbia Honard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours 238.64.7903 NC Director 02 26 6 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination that to notified at once. Columbia Howard MD 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21045 Court Stone USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify \$ American 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Gollege (1-4or 5+) Government termation Specialist Federal 2th grade VEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roosevelt Wilkins Richardson Mayomio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Matthews Stone Court Columbia MD 'Husband 5352 Nd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/10/08 Olarksville, MD Columbia Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Fundral Senices lighn Road Ray dallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, each as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancren Physician A denocarcinima tic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30573 8-08 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) Patuxent Parkney Columbia MD 21044 Little 11065 31. Date filed (Month, Day, Year) MAY 13

DHMH 17 Rev 1/2001

State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death # Month MARY WHITE a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 23 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 ☐ M 2 ☑ 214-24-8305 78 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD. Anne Arundel Co. Pasadena 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21122 758 209th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUN HOME Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stavely Mildred Ruh1 Sr. Roland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9365 Melbourne Dr. Colorado Springs, Colorado 80920 19a. Informant's Name/Relationship (Type. Print) Laura Mescher, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/08 Balto, Md. 4 ☐ Donation ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Baltimore, Md. 21225 21. Signatur Funeral Service L consee Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one sause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) 3 years Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Month Day 5 Other (specify)

Physician /Medical Examiner

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Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itel

Baltimore, Maryland 21215-0036

the attending physician signed by i this certificate After within 24 hours after death To the Funeral Director:

or Attending Physician: The law requires that the death certificate be executed

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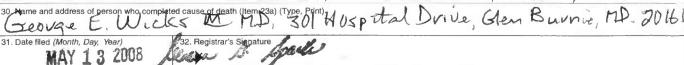
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Division or Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23h. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 20 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 [4] Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) May 5, 2008 29c. License number D 4 1365 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) MAY 1 3 2008



Michael Girard Wilson 08-03319 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month **Medical Examiner** 0202 hrs MICHAEL GIRARD WILSON May 1, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Director Months Days Hours 154-76-1163 XX M 2 F 23 6-25-1984 Country) NEW JERSEY Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show NJ. MERCER TRENTON X Yes 2 No death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 GREENWOOD AVE. 08609 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White, etc. 2 Yes permit. Pages I and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in Yes 2 X No specify: BLACK 4 Divorced 3 Widowed If Yes, Give Year Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 -12-DIETARY AIDE -0-MEDICAL 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be MICHAEL WILSON STEPHANIE BYRD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE BYRD-WILSON (MOTHER) 3931 FLOWERTON RD. BALTIMORE, MARYLAND 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Burial Cremation 3 χ Removal from State LANSDALE CREMATORY 5-9-2008 Donation Other Specify. LANSDALE, PENNA. HIBN FARName and Address of FacilityANDERSON FUNERAL SERVICE 21. Signature of Funeral NAHTYMOL D. 300 N. WILLOW ST. TRENTON, NEW JERSEY 08618 t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** lure. List only one cause on each line Between Onset and 'Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease or Andition resulting in death) Death xamine Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical signed by the attending physician are be detached for use as the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 🗸 Yes Yes 2 No No To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: ٩ 1 V Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: May 1, 2008 Subject shot __ Natural 0126 hrs Yes 2 V No hours after death. Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4100 Newbern Avenue, Baltimore, MD determined (Specify) Local Street 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 1, 2008 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Risistrar's Signatur State 2008 3 Traffe A.B.

Registrar

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Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	· ·									
Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	3 PEND	3 turne and address of person who completed cause of death (Item 23a)								
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f Vit Physic er this c	⊢	1 Yes 2 No	,p	itpatient 3 DOA	njury at Work?	28d. Describe ho	w injury occurred	
on of \nding Phy tth. r: After tf	tion:	May May	te of Injury nth, Day Year) 2008 4, 2008 Unk	Hrs 1	Yes 2 ✔ No	Subject hang		
Division of Vital Records, tal or Attending Physician: The law requinary after death. In Director: After this certificate has been significate in by the funeral director, page 2 should be the funeral director, page 2 should the control of the funeral director.	ifical	3 Suicide 6 Could not be	ace of Injury - At home, fa	rm, street, factory, office	e building, etc.	28f. Location (Str or Town, Sta	eet and Number or ite) ad , White Hall, N	Rural Route Number, City
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys complete, filled in which funeral director, page 2 should be delatched for use as the b		4 Hornicide	(y) Single Family	ath accurred at the time.	date and place a	nd due to the cause	(s) and manner as s	stated.
Di To the Hospital within 24 hours a To the Fineral	Medical	(Check only one) 2 Medical Examiner: On the base	is of examination and/or it	nvestigation, in my opini	ion, death occurred	d at the time, date a	nd place, and due to	o the cause(s)
To To To To	Med	29b. Signature and title of certifier	r stateu.	29c. Lice	ense number		29d. Date signed (Month, Day, Year)
		(alunn)	\bigvee).	0.0	C.M.E.		May 5, 2008	
		30. Name and address of person who completed of Zabjullah Ali, M.D. Assistant Med	adse of death (Item 23a) dical Examiner 11	11 Penn Street, Ba	altimore, MD 2	21201		
	State	31. Date filed (Month, Day, Year) 32	Registrar's Signature	1 4-				
Regi		MAV 1 a 2000 8	from the	great)	<u> </u>		OCME	
DHMH 17 Rev 1	/2001		OF	IGINAL			OUNE	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph 4 1530 M Anthony Adroved Jr. MAY /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner George's Prince Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Hours **X**XM 2□ F Months Days 575-41-1992 24 NOV.20,1983 Florida Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, It o Medical Examiner must be notified at Director 1 ☐ Yes 2X XX MD St. Mary's Charlotte Hall 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code P. O. Box 331 20622 S. A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes XIXNo Specify 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. <u>Appliance Repairman</u> Sears Department of Health and Mental Hygie Important: If Item 27 Is marked other I any injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph A. Adroved မှ Dorothy Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Adroved/Mother 2815 Lomax Ct. Waldorf, Maryland 20602 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition p∰Burial 2 ☐ Cremation 3 ☐ Removal from State May Trinity MFM Grdns: 9,2006

22. Name and Address of Facility
Raymond Funl. Service, P.A.

To Plata MD 20646 4 ☐ Donation 5 ☐ Other (Specify) Walderf, Maryland 21. Signature of Funeral Service License M00641 5635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE INJURY BRAIN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHEST if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit AVULSION Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28d. Describe how injury occurred Front PASS engers Driver 28c. Injury at Work? After control st 1 Natoral 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident struck parked c 28f. Location (Steet and Number or Rural Route City or Town, State) 1000 Rural Route 57 Punk Drive Was 3 Suicide 6 Could not be determined 4 Homicide

P.0. Records, of Vital Division Hospital or Attending 24 hours after death Funeral Director: A filled in by the completely within 2.

> 5 State

Medical

29a. Certifier

(Check only one)

Registrar DHMH 17 Rev 1/2001

WILLIE BLAIR, 31. Date filed (Month, Day, Year) MAY 13 2008

29b. Signature and title of certified

29c. License number D2189

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M D 7525 GREENWAY CNTR.STE.211 GREENBELT, MD 20770

been signed the should be detailed To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of CORONARY ARTE	contributing to death but not resulting in the underly	ying cause given in Part I.		cco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
DMI			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of
25. Was case referred to medical examiner?			th (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing H	ome 5 Residen	ce 6 □Other (Specify)
27. Manner of Death 1		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	rinjury occurred
3 ☐ Sulcide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place gation, in my opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as stated. ee and place, and due to the cause(s)
29b. Signature and title of certifier	1	29c. License number	290	d. Date signed (Month, Day, Year)
Valsahart	1 Jamas	D58655		05/09/08

56

3. Time of Death

15:56

10d. Inside City Limits

Approximate Interval Between Onset and Death

IWK

IWK

1 DAY

1 ☐ Yes 2 No

9. Birthplace (State or Foreign

WHITE

State

Registrar

NAWAB, SABAHAT, M.D., 32 CORPORATE DRIVE, GRANTSVILLE, MD 21536

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 13 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 9:25 P 23, April 2008 Rlank Reva /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 13702 Sloan Street Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 M 2 KF 74 December 21,1933 New York Director 050-26-3281 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "nature." 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20853 U.S.A. 13702 Sloan Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify þ 3 X Widowed 4 □ Divorced Year or Dates: Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payro11 **Bookkeeper** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Pincus Barbara Brod 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9137 Chesley Knolls Court, Gaithersburg, Maryland 20879 Maxine Blank - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ☐ Removal from State Judean Memorial Gardens 04/25/2008 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** 2 months Respiratory Failure /Médical Due to (or as a consequence of) Examiner 20 years Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duly to for as a consequence of) Examiner Decades Smoking burial-tra Due to (or as a consequence of) physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 2 X No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 X Natural 5 ☐ Pending investigation

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: filled in by the funeral After after death. within 24 hours a

To the Funeral I

completely filled

2 Accident

29a. Certifier (Check only one)

3 ☐ Suicide

6 ☐ Could not be determined 4 Homicide

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D36252

1 ☐ Yes 2 ☐ No

April 24, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who complete d cause of death (Item 23a) (Type, Print)

Steven Toshihiro Kariya, M.D., 10605 Concord Street, #500, Kensington, Maryland 20895

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ID

			For State Registrar	State of M	1aryland	-	artmen <i>tificat</i>			and M	ental Hy	/gien Reg. N	211	08	150	613
	Physic /Medi		1. Decedent's Name (First, Middle, Last, Ruth Ann Bress								2. Date of D Month April	D	ay 2008	Year 8	3. Time of 1:14	f Death
	Exami		4a. Facility Name (If not institution, give Casey House	street and number	r)			Town, or	Location o	f Death	при	4	c. County	of Death		
	Funeral Director			7. A	Age (In yrs. Ia 82	s <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D 10/04)			Соці	place (State of ntry) land	or Foreign
	Maryland f show ied at	tor	Usual Residence of Decedent	·v		Town or Lo	cation								l0d. Inside Ci 1 X Yes	ity Limits
	h with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 6708 Pemberton Str				10f. Zip					-	itizen of V		-	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Pyes 2 If If Yes, Give Year or Dates	t Ever in U.S ?]No 1940 1970	J-	Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)	0-	Blac	e - Americ k, White, Whit		
Maryland 21215-0036	d within 72 ho giene. Ir than "natu the Medical	Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or	5+)	16a. Deced (Give life. L Homema	kind of woi OO NOT us	al Occupa rk done d se retired	ation luring most)	of workin	g		Kind of Bu		dustry	
yland	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Alex Robert Klotz			_			18. Mother		(First, Middle avis	e, Maide	en Surnam	e)		
	1 and 2 sho Health and Hm 27 is ma		19a. Informant's Name/Relationship (Ty Toni Lee Blate / I 20a. Method of Disposition	•	20h Blo	1033	l Wat	tkins	s Mil	1 Dr	Route Numi	gome	ry V	illa	ge MD	20886
Baltimore,	it. Pages artment of h intant: If its njury or of		1 Nation of Disposition 1 Nation		5	ice of Dispos metery, cren ington	Nat	. Cer	$net^{(0)}$	5/02,	/2008	Ar1	Location -	on, V	VA.	
Ba	Depar Impor any Ir		23a. Part1. Enter the disease, or compl	Burg	of the death	51	30 W	İscoı	nsin A	Ave.	eph Ga NW Wa	shin			20016	to.
18.0	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Colon	line.	r	or the mod	o or dynn	y, 30011 a3 1	cardiac of	respiratory	anest,			Approximat Interval Bet Onset and I	ween Death
8760,	Examine be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		s a conseque s a conseque											
P.O. Box 687	eath certifii attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2□XNo 9□Unknown	3c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 🔲 Fetal o	death 3	Ectopic pr						23d. Dati Mor	e of delive	•	Year
	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions con	ntributing to death	but not result	ing in the un	derlying ca	ause give	n in Part I.						he cause of d bably 4 ⊠l	
or Vital Records,		Completed									24a. Was auto perf 1 Yes		p	Were auto prior to co leath? Yes	ppsy findings mpletion of ca 2 □ No	available ause of
	ng Phys fter this neral dir	ation: To Be	27. Manner of Death 1 🛣 Natural 5 🗆 Pending 2 🗀 Accident investigation	1 ☐ Inpat 28a. Date of Inj (Month, D	jury 2	R/Outpatient 28b. Time of Injury		8c. Injury Work	r: 4 🗆 Nur	rsing Hom	(Check only ne 5 ☐ Res 8d. Describe	idence			Mospi	ce-ip
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined		etc. (Specify)						City or To	wn, Sta	te)		al Route Num	nber,
	the Hosp hin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one) Oob Circulation of the control of	ner: the basis	of examination	ledge, death on and/or inv	estigation,	in my or	pinion, deat	d place, a th occurre	nd due to the	, date a	nd place, a	and due to	o the cause(s	3)
		~	29b. Signature and title of certifier	Cleru	5)		DO	. License)0646					il 1		Day, Year) 008	
			30. Name and address of person who co Genevieve Wroblews 31. Date filed (Month, Day, Year)	ski MD 60		ncaste		L1 Ro	i. Ro	ckvil	lle, M	D 20	855			
	Sta Registr		APR 2 8 200		irai s Signalu		1									

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 23-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anner Annapa If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min, A Months 1□ M 2□F N Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28s-f ehow eny injury or other traumatic event, Ite Medical Examinar must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Ob. County 1 ☐ Yes 2 🗷 No WV Completed by Funeral Director ton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Bi - racia 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Backmes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tmes 2 homas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Herring Creek Oden to m Ms 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 4/28/2008 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Dicensee Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Approximate
Interval Between
Onset and Death

W Stur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician orematur trem /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence on: Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes 2 🗸 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

sician and e burial-transit or Attending Physician: The law requires that the death certificate be executed Box 68760. to P.0. signed t Division of Vital Records, page 2 should this certificete After th funeral death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi To the Hospital

Baltimore, Maryland 21215-0036

Medical Certification: To

ocation (Street and Number	or Rural	Route	Number

29a. Certifier
(Check only
one)

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 34d title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

wen lema person who completed cause of death (Item 23a) (Type, Print) Md 21409 2001 Annapolis Medical

31. Date filed (Month, Day, Year) State Registrar

APR 2 8 2008

32. Pegistrar's Signature

Aluk Kumart

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician /Medical Examiner sician and bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the burial SB attending asn lor

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

the Medical E

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other than any Injury or other traumatic event, the gones.

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

signed by the a s certificate has be lirector, page 2 s funeral director, this After within 24 hours after death.

To the Funeral Director; /
completely filled in by the f

Completed by Physician/Medical Be P

Examine 27. Manner of Death

Medical Certification:

the 101 Registrar

State

(Check only one) 29b. Signature and title of certifier HAKIM WYEL 31. Date filed (Month, Day, Year) APR 2 8 2008

1 Natural 2 Accident

3□ Suicide

4 Homicide

28a. Date of Injury

(Month, Day Year)

29c. License number

BLUD

28c. Injury at Work?

🖊 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ∏ Yes 2 ∏ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

21239

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

BALTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

5 Pending investigation

6 ☐ Could not be

determined

LOCH

32. Raistrar's Signature

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	1 - For State Registrar		State of		•	rtificate of	Death		Reg. No.	2008	15617
P	Physici	an	Decedent's Name (Firs							2. Date of De Month	Day	Year	3. Time of Death
	/Medic				ese Boss					April	22	2008	5:00 p. M
	Examin	er	4a. Facility Name (If not in	_		oer)			r Location of Death			ounty of Death	
35	b	*	Mallard Ba 5. Social Security Number			. Age (In yrs. I	ast hidhday)	Cambri	dge If Under 24 Hrs.	8. Date of Bir		Dorches	Ster place (State or Foreign
	Funeral Director	i X	220-01-8944 Usual Residence of Dece		1 M 2 K F	100	Yrs.	Months Days	Hours Min.	April 8	y, Year)	Coui	yland
	land ow t			County		10c. City	, Town or Lo	cation					10d. Inside City Limits
\bigcirc	Maryland -f show fied at	to	MD	Talbo	t			Easto	n				1XYes 2□No
K	death with the ms 23a or 28a r must be noti	Funeral Director	10e. Street and Number					10f. Zip Code			10g. Citize	n of What Cou	ntry?
2	th wit 23a o Ist be	alD	408 Cheri	y St.					21601			USA	
0	ems ems	Iner	11. Marital Status		12. Was Deced Armed Force	ent Ever in U.s	3. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14	. Race - Americ Black, White,	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2		1 ☐ Yes 2 If Yes, Give Year or Date	No No		1 □ Yes 2 🕱 No		7110411, 0101,			nite
5-0	72 ho natur dical	eted	15. D (Specify on	ecedent's E	ducation ade completed)		16a. Dece	dent's Usual Occup	oation during most of work d)	ina	16b. Kind	of Business/In	dustry
2	12 should be filed within hand Mental Hygiene. 7 is marked other than "fraumatic event, the Mec	Completed by	Elementary/Secondary		College (1-4	lor 5+)		DO NOT use retireo afeteria		9	nuh	olic sch	2001
121	lled w Hygie her tl nt, th	Ŝ	17. Father's Name (First,	Middle Last	9			areceria	18. Mother's Nam	e /First Middle			1001
anc	I be fi	Be	Ernest Aug							a Horwa		urname)	
Ž	hould d Me mark matic	ဥ	19a. Informant's Name/R				19h Mailir	na Addross (Straat	and Number or Rui			Four State Zin	Code)
Ma	d 2 s th an th an traul		Ann Sharif		dauql	hter	1		of Eden,				
	Health tem 27		20a. Method of Disposition					sition (Name of matory or other place		Date		tion - City or T	
ω	Pages ent of nt: If I		1 X Burial 2 □ Cred 4 □ Donation 5 □ 0						ery 4/28	3/08	Eas	ston, MI)
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral				22	2. Name and Addre	ss of Facility Tr	iomas Fi	neral	Home 1	
			Oce Ports Setes the die	,	uliantiana that an	up a d the plants		***	t St., Ca		·	21613	Approximate
п			23a. Part1. Enter the dis- shock, or heart failu Immediate Cause (Final	re. List only						or respiratory a	rrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		_a		stag	e De	mehrz				
	Examiner				Due to (or	r as a consequ	ience of).						
	. (意	er	Sequentially list condition if any, leading to immedia	s,	b. — Due to (or	r as a consequ	ience of):						
	uted d ansit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	0								
ó	tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last		Due to (or	r as a consequ	ience of):						
68760,	nte be nysicia ne bu	edical			d								
	± og ë		IF FEMALE:										
O. Box	requires that the death cert een signed by the attending rould be detached for use a	Physician/N	23b. Was decedent pregi in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			th 2□Fetal nt at time of de	death 3	Ectopic pregnanc Other (specify)	у		230	d. Date of deliv Month	ery Day Year
Δ.	that the ded by		Part II. Other significant	conditions	contributing to dea	th but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
Records,	w requires that the desired speed signed by the should be detached	Completed by								1 🗆	Yes 2	No 3□ Pro	bably 4 □Unknown
တ္တ	- 0 -	olete								24a. Was	an	24b. Were auto	opsy findings available ompletion of cause of
æ	sician: The law s certificate has b irector, page 2 s	шо								auto perfo 1□ Yes	psy ormed? 2010	prior to co death? 1 ☐ Yes	mpletion of cause of 2√2 No
Vital	ian: rtifica tor, p	BeC	25. Was case referred to	medical					26. Place of Deat			1 1 1 63	20110
r <	<u>> .⊍ 0</u>	0	examiner? 1 ☐ Yes 25€No		Hospital: 1 Inp	patient 2 🗆 I	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho	ome 5 ☐ Resi	dence 6	□Other (Speci	fy)
0 4	ng Pł fter tł neral	L ii	27. Manner of Death Natural 5	Pending	28a. Date of	Injury , Day Year)	28b. Time of Injury	f 28c. Injur Wor		28d. Describe			
310	Attending r death. ector: After by the fune	atic	2 ☐ Accident	investigatio				M 1□	Yes 2□No				
Division or	al or Att	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	Zoe. Flace 0	f injury - At ho g, etc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f. Location (City or To	Street and i wn, State)	Number or Rur	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical				sis of examinat			me, date and place opinion, death occu				
	o the orther orther omple	Mec	29b. Signature and title o	certifier	All y			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	/ /		•), l	augher	MD		D 4	17924		4,	125/05	-
	5	1	30. Name and address of	person who	completed cau e	of death (Item	23a) (Type,				. /	1-0	
			NOMAN	THAN		503 B			AMBRID	G E	MD	2161	3
	Sta Registr		31. Date filed (Month, Da	PR 2	5 2008 ^{32. Rec}	gic rar's Signa	ture	South					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	Maryla	•	irtment of I <i>tificate of</i>	Health and Death	Mental H	ygie: Reg.			
-	Diam'r.	R	Registrar 1. Decedent's Nam	e (First, Middle, Las	rt)		001	imouto or		2. Date of D	eath	- 6	Q 0 8	3. Time of Death
	Physicia /Medic		Joyce Ma		Bernste:					April				6:00 P M
	Examin	er	3428 Shad	lf not institution, give ly Lane	street and nun	nber)		Glenwoo	or Location of Deat d	n		4c. Coun Iowar	ty of Death	
	Funeral Director		5. Social Security N 151-30-72	lumber 6. So	9X □M 2 X F	7. Age (In y	rs. last birthday) 70 Yrs.	If Under 1 Year Months Days			irth Day, Ye	938	9. Birthp Cour New	place (State or Foreign ntry) Jersey
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c.	City, Town or Lo	cation					1	I 0d. Inside City Limits
	Maryli I-f sho fied al	tor	MD	Montgome	CV	01	ney							1 □ Yes 2√ No
	or 28s	Direc	10e. Street and Nu	mber				10f. Zip Code			_		f What Cour	ıtry?
	eath w	Funeral Director		gers Glen	Drive 12. Was Dece	dent Ever in	118 13 1	20832	Hispanic Origin? (9	Specify Ves or N	USA		ace - Americ	ean Indian
9	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		 Marital Status Never Mari 	ried 2□ Married	Armed Fo 1 ☐ Yes	rces? 2 X No	i i	f Yes, specify Cul	Hispanic Origin? (Span, Mexican, Puer	to Rican, etc.)	10-	ВІ	ack, White,	etc.
5-0036	ural", c	d by	3 Widowed		If Yes, Giv Year or Da	e ates:							ify: Whi	
۲. د	in 72 l n "nat Aedica	plete		15. Decedent's Ed	de completed)	4 5-\	(Give	lent's Usual Occu kind of work done OO NOT use retire	pation e during most of wo ed)	rking	160	. Kind of	Business/In	dustry
717	filed within 7 I Hygiene. other than "r ent, the Med	Completed	Elementary/Seco		College (1	-40r 5+)	Teach	er	1			lucat		
and	t be file ntal Hy ed oth	Be		(First, Middle, Last) Frank Cal					18. Mother's Na	, .			,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Importament of Health and Menth Hygiene. Inportament if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	유	19a. Informant's N	ame/Relationship (7	Type. Print)				t and Number or R				n, State, Zip	Code)
	and 2 ealth a n 27 is ier trai		David Ber	rnstein/so	o n				ne Glenwo					
Baltimore,	ages 1 int of H or oth			Cremation 3 🗆		State		sition (Name of natory or other pla e Cremat		Date 29/08			.11e,	
	artmer artmer ortant injury			5 ☐ Other (<i>Specif</i>) uneral∕Service rt icen		CI	•	-	ess Creillati					
ñ	Dep Imp any		1 Dec	reely & t.	telet	e Mo								e, MD 21029
			shock, or hea	the disease, or compart failure. List only	one cause on e	ach line.	^	,	2	c or respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final on	u	ASTAT	sequence of):	realic (ancer				- (9 months
	Examiner		Conventially list on	andition o	h	or as a come	ioquonico oi).							
*	ed sit	iner	Sequentially list contains, leading to in cause. Enter Under Cause (Disease or	oriditoris, inhediate erlying	Due to (or as a cons	equence of):							
,	execut n and ial-tran	Examiner	that initiated events resulting in death)	S	cDue to (or as a cons	sequence of):							
8/6U	icate be executed physician and s the burial-transit	dical			.d									
٥	certifica ding ph	/Med	IF FEMALE:		23c. If yes, out	come of ore	ananov							
ROX	death certif e attending d for use as	Physician/Me	in the past 12	2 months?	1□Live b 4□Pregn	irth 2□F ant at time o	etal death 3 [Ectopic pregnand Other (s <i>pecify</i>) _	су				ate of delivention	ery Day Year
z Ö	at the o	hys	9 □ Unknowr	i	9□Unkno							J		
ds,	w requires that the death certif been signed by the attending should be detached for use as	ρ	Part II. Other signi	ificant conditions o	ontributing to de	eath but not	resulting in the u	nderlying cause g	iven in Part I.		l tobac] Yes	co use co 2 No		he cause of death? bably 4 ∏Unknown
cords,	law requas been 2 should	letec								24a. Wa		-	o. Were auto	opsy findings available
Ŷ	The law ate has l	Completed								aut	opsy formed		prior to co death? 1 ☐ Yes	ompletion of cause of 2 □ No
VITal	Physician: The this certificate he ral director, page	Be	25. Was case reference examiner?	rred to medical	Hospital:				26. Place of De					son's
_	hys l di	<u>:</u>	1 Yes 2 27. Manner of Dear		28a. Date	of Injury	ER/Outpatien	I 3 DOA		lome 5 ☐ Re	_			ty) nome
<u>0</u>	ath. ath. or: Afte	atior	1 X Natural 2 ☐ Accident	5 ☐ Pending investigation		h, Day Year) Injury		ork? ∐Yes 2∐No					
UNISION	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	Zoe. Flace	of injury - Ang, etc. (Spe	t home, farm, str ec <i>ify)</i>	eet, factory, office		28f. Location City or T			nber or Rura	al Route Number,
_	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.		29a. Certifier (Check only						time, date and place					
	the Hin 24 the Fu	Medical	one)	2 Medical Exan	and mani	ner stated.	illiation and/or in		se number	at the tim			e, and due t	
)	F N O		29b. Signature and	has W. 1	Lieba	15	my		20000		1	1	1 - 15	
(3	-),2-		30. Name and add	ress of person who	ompleted cause	e of death (I	tem 23a) (Type,	Print)		5/		11	1	, 21044
	/U-0		NIChul 31. Date filed (Mor	MSKI 10	whela	istrar's Si	11065 L	ittle PA	50509 TUXENT	Tactura	4 C	vlun	chim	may lows
	Sta Registr		J. Date filed (IVIOI		กกล 🌯	Gelias I	# 4	bout !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Mary E. Brown 11:41 A. May 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs. (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Numbe 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2√2 F 71 220-32-7137 December 29, 1936 Upper Marlboro.MD. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1916 Village Green Drive 20785 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's County Elementary/Secondary (0,12) College (1-4or 5+)

Baker

Public School System

18. Mother's Name (First, Middle, Maiden Surname)

Anna Belt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Extending Interinant be recified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Maryland

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

James F. Swann

3. Registrar's Signature

MAY 13 2008

31. Date filed (Month, Day, Year)

Director

Funeral

þ

Completed

Be

၉

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed yithin 24 hours after death.

7 to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Mr. James T. Brown (So	on)	911	18 D'Arcy F	Road Upper	Marlb	oro, Maryla	and 20774	+
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of I cemetery Moses Ce	Disposition (Name of crematory or other metery	of place) Ma	ny 7, 20		Location - City of nian, Mary	,
	21. Signature of Funeral Service Licens	Leis		22. Name and A			ins Funera hington, D	,	
	23a. Per 1. Enter the disease, or compensor, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Cardi Due to (or as a	omyopa consequence of	thy				se	Approximate Interval Between Onset and Death
Car Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of						
Iysiciai/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregi 5 ☐ Other (specif			1	23d. Date of de Month	elivery Day Year
ed by r	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlying cause	e given in Part I.		23e. Did tobacco		to the cause of death? Probably 4 Unknown
na di librar							24a. Was an autopsy performed?	24b. Were a prior to death?	autopsy findings available completion of cause of
2	25. Was case referred to medical examiner?				26. Place	of Death (C	Check only one)		
5	1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🔀 R/Out	patient 3 DOA	Other: 4 \sum Nurs	rsing Home	5 Residence	6 ☐ Other (Sp	ecify)
	27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. Ti	me of 28c.	Injury at Work? 1 □ Yes 2 □ N	28d	f. Describe how in		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farr <i>(Specify)</i>	n, street, factory, off	ice	28f.	Location (Street City or Town, Sta		Rural Route Number,
מחכם	29a. Certifier (Check only one) Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	examination and	death occurred at t /or investigation, in	he time, date and my opinion, deatl	d place, and th occurred	d due to the cause at the time, date a	e(s) and manner a and place, and du	as stated. ue to the cause(s)
	- Jarray /	unale	MD	29c. Lie	cense number	52/3	29d. [Date signed (Mon $\frac{1}{3}$	70770.
	30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (1 7525	ype, Print) Green Wa	y ctr. D	or. G	resube	lt MD	20770.

DHMH 17 Rev 1/2001

State

Registrar

3

State of Maryland / Department of Health and Mental Hygiene, For State Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** mawell 7:50 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Ab. City Town, or Location of Death Examiner 445T Morcester OcomoKE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-20-1915 Birthptace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 2 1 □ M 2 2 F aMD 213-16-8356 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 100-City, Town or Location 10d. Inside City Limits id other then "natural", or items 23a or 28a-f show event, the Madical Examinari, ust be multiped at ocomoke 1 XYes 2 ☐ No **Funeral Director** MDWorcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iter ampiniury or other traumatic event, the Mudical Exacultations. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 13 ack Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) abor Health Home 17_Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ollic aymond (アシャロ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Banks St. MD 21851 l'ocomoke, Murray - Daughter 402 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriat 2 Cremation 3 Removal from State 5hiloh 04-30-089 L'ocomoke Cemotery *4 Donation 5 Other (Specify) 22. Name and Address of Facility Anthony E. Ward Funeral Home 21. Signature of Funerat Service License 30039 Hampden Are. Princes Anna, MO 21853 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagh line. Approximate tnterval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Director: After to in by the funeral 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of tniury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide the Funeral 24 hours crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. within To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number death (ttem 23a) (Type, Print) 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** William W. Clark, Jr. Apri1 25. 2008 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Davs Hours Min. 1 ☑ M 2 ☐ F 87Yrs. Sept. 13,1920 Wisconsin Director 389-16-3219 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. It was 23 or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extrairer must be retified at 10a. State 1 ☐ Yes 2 👿 No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 853 Woodmont Road 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ဩYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1943–64 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pilot U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William W. Clark, Sr. Estelle Junkman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr 853 Woodmont Road Annapolis, Maryland 21401 Maxine N. Clark / Wife Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Natl. Cem. 7-16-2008 | Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Fun ral Service Licensee 2973 Solomons Island Rd. Edgewater, MD. 21037 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Examiner Aurens Staph Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): O. Box 68760. physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 00005829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I context mapplis MD 2140 Anne Avandel M

DHMH 17 Rev 1/2001

Registrar

HOWARD

strar's Signature

MD

YOUNG Year) 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			, For	te of Maryland					∕lental Hy	giene		
			State Registrar		Cei	rtificate	of D	eath		Reg. No.	008	15622
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Bessie Co	ley					2. Date of De Month April	Day 21, 2	2008	5:40 A M
	Examin		4a. Facility Name (If not institution, give street a					ocation of Death			ty of Death	***
-	<u>Spirotes de la la la la la la la la la la la la la </u>		St. Thomas Moore Nur 5. Social Security Number 6. Sex	7. Age (In yrs. la		Hyatts If Under 1		.e f Under 24 Hrs.	8. Date of Bir	th	e Geo	lace (State or Foreign
	Funeral Director		579-24-7630 1□ M 2			Months [Days	Hours Min.	(Month, Da Aug. 2, 1	y, Year)	Cour	arolina
	P.		Usual Residence of Decedent	10- 00	Town or Lo	agtion						0d. Inside City Limits
	show	5	10a. State 10b. County									1 √ Yes 2 No
	the M 28a-f	rect	Md Prince Georg	ge Hyat	tsv11.	le, Md				10g. Citizen o	f What Cour	ntry?
	3a or	io le	4922 Lasalle Rd.			2078				USA		,
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	Arr	s Decedent Ever in U.S ned Forces? Tyes 28 No	S. 13.	Was Deceder If Yes, specif	nt of Hisp y Cuban,	panic Origin? (Sp Mexican, Puerto	pecify Yes or No o Rican, etc.)	14. R	ace - Americ lack, White,	
altimore, Maryland 21215-0036	urs af al", or Exam	by	It /	es, Give ar or Dates:		1 □ Yes 2¥	No	Specify:		Spec	cify: Bla	ck
2-Ç	72 ho natur fical	Completed	15. Decedent's Education (Specify only highest grade comp	eleted)	16a. Dece	dent's Usual kind of work	Occupati done dui	on ring most of wor	king	16b. Kind of	Business/In	dustry
2	vithin ne. han "	mple		llege (1-4or 5+)		<i>DO NOT use</i> memake				Priva	te In	dustry
7	filed v Hygie other 1		17. Father's Name (First, Middle, Last)					8. Mother's Nam	ne (First, Middle	, Maiden Surn	ame)	
a	lid be lental rked c	To Be	Sam Burford					Laura	(unknowr	1)		
lary	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type. Pri	nt)	19b. Maili	ng Address (S	Street an	d Number or Ru	ral Route Numb	er, City or Tow	ın, State, Zip	Code)
S,	of Health a item 27 is	1 3	Bessie Johnson/Frien			Leeds		Suitla	nd, Mar	y1and 20c. Locatio	20746	
סר	8 = = 4	3	20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Remova		emetery, cre	matory or oth	er place)	i			-	
in the		1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Ft.	Linc	oln 2. Name and	Address	Apr.	24,2008 tney's	Brentv Funeral	Vood,	Maryland
Ř	permit. Departr importa any Inju		#:	278 MD					N.W. Wa			
-	7-1-		23a. Part. Enter the disease, or complication shock, or heart failure. List only one cau		. Do not en	ter the mode	of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	Terios.	clevo	tic C	ANd	FOVESC	var 1	Sisea	Se	Onset and Death
•	/Medical Examiner		Testing in death)	Due to (or as a consequ	ence of):							•
b		Jer	Sequentially list conditions, b.	Due to (or as a consequ	ence of):							
	cuted nd rransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
8/60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):							
289	ficate I physics the t	edical	d									
ŏ	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	23b. was decedent pregnant	es, outcome pf pregna Live birth 2 🗆 Fetal		□Ectopic pre	gnancy				Date of deliv	ery Day Year
O. B	at the dea by the at tached fo	ysici		∃Pregnant at time of de ∃Unknown	eath 5	Other (spec	cify)				Mondi	Day Tour
<u>a</u> .	that the		Part II. Other significant conditions contributi	ng to death but not resu	ilting in the u	ınderlying cau	use given	in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
rds,	w requires that s been signed b should be deta	ed by	Demontin						10	Yes 2□ No	3 □ Pro	bably 4 Honknown
Hecord	law re as bee 2 sho	Completed	Peripheral Vas	cular Di	teg				24a. Was	an 24	b. Were auto	opsy findings available ompletion of cause of
_		Com	3. lateral abo	UP Knee	au	nog	at	201	perf 1□ Yes	ormed? 2 █ No	death? 1 ∐ Yes	2 □ No
VII a	sician certifi rector	Be	25. Was case referred to medical examiner?	1:		274.77	Othor	26. Place of Dea	th Check onl			
ō	Phys er this eral di	. To	1 163 2 140	Date of Injury	28b. Time o		c. Injury a Work?	4 La Nursing F	lome 5 ☐ Res 28d. Describe			f(y)
0	ath. rr: After ne funera	atior	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		es 2 □ No				
Division or	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificativi filled in by the funeral director, tely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28€	. Place of injury - At ho building, etc. (Specify	me, farm, st	reet, factory,	office		28f. Location City or To	(Street and Nu wn, State)	mber or Rui	al Route Number,
	pital or ours afte eral Dir filled in		29a. Certifier 1 ✓ Certifying Physician	To the best of my know	wledge, dea	th occurred a	t the time	e. date and place	a. and due to the	cause(s) and	manner as	stated.
_		edical	(Check only 2 Medical Examiner: C	n the basis of examinat	tion and/or in	nvestigation, i	in my opi	nion, death occu	urred at the time	, date and place	ce, and due	to the cause(s)
	within 2 To the complete	Me	29b. Signature and title of certifier			29c.	License i	number		29d. Date sig	ned (Month	, Day, Year)
			Sunland	Vise Cin			10	45		APR	L 21	2008
			30. Name and address of person who complet	ed cause of death (Item	23a) (Type,	Print)		h 121 /) . / k 1.	116	- 1/ a A	Day, Year) 2008 M) 20181
7	Sta	ate	31. Date filed (Month, Day, Year)	25 MJ V2	ture	VUEV.	eus!	1012	-1 144	4015V	111	VI) 2, VI
	Registi		APR 2 9 2008	Bullius L	y A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** 6:30 pM James W. Crawley, II April 22 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthdav) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1**№** M 2□ F Director 450-08-0521 51 May 25, 1956 Oklahoma Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits rai", or items 23a or 28a-f show Ex∗miner must be notifled at 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Pembrooke View Lane 20877 U.S.A. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed withir al Hygiene. I other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Journalist Media General 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill int of Health and Mental H it item 27 is marked ott Be marked c James W. Crawley Rachel Hoffell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melba Crawley - Wife 110 Pembrooke View Lane, Gaithersburg, MD 20877 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a, Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 05/01/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 ala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Renal Cell Cancer Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and -tra Due to (or as a consequence of): physician ar Box 68760 Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. I ☐Yes 2☐No detached the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu death.

To the I within 2. 10

Registrar DHMH 17 Rev 1/2001

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ORIGINAL

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chitra Desikan Kajagopal,

APR 29

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D42452

M.D., 18111 Prince Philip Drive, #327, Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

April 23, 2008

		Registra MEND#3	penurb-1		Apryland Co	d / Depa Cea	artment rtificate	of Health of Deal	h and M		Reg. No. 🛴	008	15621
Physic /Medi		Decedent's Name (First Th		ervey Conn	or					2. Date of De Month April	Day	Year 2008	3. Time of Death 4:45PM
Examir	ner	4a. Facility Name (If not in	_		r)		4b. City, To	own, or Location Adelph				nty of Death	George's
Funeral Director		5. Social Security Number 146-18-5338	6. Se		Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months	-	der 24 Hrs.	8. Date of Bin (Month, Da April	rth	9. Birth	place (State or Foreign ntryNew Jersey Heryland
yland now		Usual Residence of Deceded 10a. State 10b.	dent County		10c. City,	Town or Lo	ocation						10d. Inside City Limits
be filed within 72 hours after death with the Maryland that Hygiene. So other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	Maryland	Prince	George's				Ade1	phi				1 ☐ Yes 2 🖾 No
with the a or 2.		10e. Street and Number					10f. Zip C				10g. Citizen		
death ms 23 r must	Funeral	10104 Gree	en Fores	12. Was Deceder	t Ever in U.S	3. 13.	Was Decede	nt of Hispanic y Cuban, Mex	783 Origin? (Spe	ecify Yes or No	o- 14. F	U.S.	can Indian,
or Ite		1 Never Married 2	_	Armed Forces 1 X Yes 2 ☐ If Yes, Give] No		ires, specii 1 □ Yes 2			Hican, etc.)		Black, White, cify:	etc.
hours tural	ed by	3 X Widowed 4 □ D	ovorced Decedent's Edu	Year or Dates	· WWII	16a. Dece	dent's Usual	Occupation		-			White dustry
0	Completed	(Specify onl	ly highest grad	le completed) College (1-4o	r 5+)	(Give life.	kind of work DO NOT use	done during r retired)	nost of worki	ng			,
filed within Hygiene. other than "		12					Super	rvisor	- M	(F) A # (-1)-			Printing Offic
d be fil	Be C	17. Father's Name (First,		n Connor, J	Tre			18. Mc		izabeth :	, Maiden Surr	name)	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.	은	19a. Informant's Name/Re			,1.	19b. Mailii	ng Address (Street and Nu			per, City or To	vn, State, Zij	o Code)
and 2 ealth a n 27 Is		Thomas E. Co		Son							Marylan	d 20902	
Pages 1 nent of Ho int: If iten		20a. Method of Disposition 1 Burial 2 Crer		Removal from Stat	e 20b. Pla	ace of Dispo metery, crei	osition (Name matory or oth	e of ner place)		ate	20c. Locatio	n - City or T	own, State
nit. Pa artmen ortant: Injury		4 Donation 5 □ 0	***		Par		demorial	Park Address of Fa	,	3/2008	Rockv	ille, M	aryland
permit. Departi) Q	laf	Donn	De	1	Hines-Ri	inaldi F	uneral l	Home, Inc	c. lver Spr	ing. Ma	ryland 20904
		23a. Part1. Enter the dise shock, or heart failu	ease, or comp ire. List only	lications that cause	ed the death. line.								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)		•	emic Car								Onset and Death 8 months
/Medical Examiner		resulting in death)			is a conseque								
	ē	Sequentially list condition if any, leading to immedia	as,	υ.	nary Art is a conseque		sease						10 years
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ficate be executed physician and strength the burial-transit		resulting in death) Last		Due to (or a	is a conseque	ence of):							
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The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as the state of the same as the state of the same as the state of the same as the same	M/us	IF FEMALE: 23b. Was decedent pregr	iani	23c. If yes, outcom 1□Live birth			⊒Ectopic pred	nancy				Date of deliv	
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that the		Part II. Other significant	conditions co	ntributing to death	but not result	ting in the u	nderlying cau	ıse given in Pa	art I.	23e. Did	tobacco use c	ontribute to t	the cause of death?
quires n sign	d by									1 🗆	Yes 2. No	3 Pro	bably 4 □Unknown
law requir as been si 2 should	Completed									24a. Was		b. Were auto	opsy findings available ompletion of cause of
	Com									perf- 1□ Yes	ormed?	death?	2□No
ysician: This certificate	Be o	25. Was case referred to examiner? 1 ☐ Yes 2 ☒ No	1	Hospital:	4:4 000	:D/O		Othor		(Check only			
Attending Physician: r death. ector: After this certific by the funeral director,	n: To	27. Manner of Death		1 ☐ Inpa 28a. Date of In (Month, D	ijury :	R/Outpatier 28b. Time o		c. Injury at Work?	T		idence 6 🗆		fy)
endin eath. or: Aff	Certification:	2 Accident	Pending investigation Could not be	(WOHA), E	yay rear)	Injury	M	1 ☐ Yes 2	!□No				
or Att	rtific	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined	28e. Place of in building,	njury - At hon etc. <i>(Specify)</i>		eet, factory,	office		28f. Location (City or To	(Street and Nu wn, State)	mber or Run	al Route Number,
spital		29a. Certifier 1 🕱 C	Certifying Phy	rsician: To the bes	st of my know	/ledge, deat	h occurred at	t the time, date	e and place,	and due to the	cause(s) and	manner as s	stated.
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	(Check only 2 N	ledical Exam	iner: On the basis and manner	of examinati	on and/or in	vestigation, i	n my opinion,	death occurr	ed at the time	, date and plac	ce, and due t	to the cause(s)
To t To t	Σ	29b. Signature and title of	f certifier				29c.	License numb	er		29d. Date sig	ned (Month,	Day, Year)
128		The state of the s	w	- m-D-	death th	00-1 (7	Delet's	D005184	41		Apri	1 28, 20	800
		30. Name and address of Brian Leona		n. M.D., 12	2520 Pro	sperit	v Drive.	. Suite	150. Si	lver Snr	ing. Mar	vland 2	0904
Sta		31. Date filed (Month, Day	y, Year)	32 egis	strar's Signat	Te A	all .	,		bpr.		, Iwill 2	U - U T
Regist	rar	APR	2 9 20	US JOSE	the so	FILE	resiliti.						

		1	For State Registrar	State of Maryland		nt of Health ar <i>te of Death</i>	nd Mental Hy	ygiene Reg. No. 20	08 1562	25
1			Decedent's Name (First, Middle, Last,)			2. Date of D Month		3. Time of Dea	th
	Physicia	_	Beatrice Irene	Cason				26, 2008		\mathbf{a}^{M}
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of I	Death	4c. County of	Death	
	LAGIIIII	•	Collingswood Nurs	ing & Rehab.		ockville			tgomery	
	Funeral		5. Social Security Number 6. Se		Months	er 1 Year If Under 24 Days Hours	Min. (Month, E		 Birthplace (State or For Country) 	reign
	Director		245-07-5053	M 2 X F 94	Yrs.		Nov.	17, 1913	North Carol	ina
	pu ,	-	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location				10d. Inside City Lin	mits
	anyla shov d at	_							1 □Yes 21X] No
	he M 8a-f otifie	Director		Arundel	Davidsonv	111e Lip Code		10g. Citizen of Wh	nat Country?	
	with t		10e. Street and Number 1128 Rutland Vi	ow Drive		1035		USA		
	be filed within 72 hours after death with the Maryland Arlydinen. d other than "natural", or Items 23a or 28a-f show do other than "natural", or Items 24a or 28a-f show event, the Medical Examiner must be notified at	Funeral		12. Was Decedent Ever in U.S		edent of Hispanic Origin becify Cuban, Mexican,	n? (Specify Yes or N		- American Indian,	
	Item Item	Ĕ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo			Puerto Rican, etc.)		White, etc. White	
ဗ္	hours after tural", or Ite al Examine	by	3*©Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ∐ Yes	2. ♣No Specify:		Specify:	WIIICE	
Maryland 21215-0036	2 hou		15. Decedent's Ed	ucation	16a. Decedent's Us	sual Occupation	of working	16b. Kind of Bus	iness/Industry	
ر د ا	filed within 72 F Hygiene. other than "nati rent, the Medica	Completed	(Specify only highest grad	College (1-4or 5+)	life. DO NOT	vork done during most of use retired)	or working			
2	d with giene ar tha	ĕ	Ziomomary, Contract y (Contract y	1	Be	autician _		Salon		
٦	be file ital Hy id othe event,	Be C	17. Father's Name (First, Middle, Last)				•	lle, Maiden Surname	")	
<u>la</u>	uld b Venta rrked rric e	ToE	James Jay Mitche	11	_		na Lee Cro	_	1717	-
ar,	es 1 and 2 should be 1 of Health and Mental 1 item 27 is marked o r other traumatic eve	ji 2	19a. Informant's Name/Relationship (7 Gary A. Groves/N			ess (Street and Number				
	and and in 27		Gary A. Groves/I				Drive, Date		Lle, MD 2103 Dity or Town, State	35
O .	ges 1 it of He If iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Disposition (A emetery, crematory of	r other place)	May 1		•	
Ĕ	Pages ment of ant; If its ury or o		4 □ Donation 5 □ Other (Specify) Ga		ven Cemeter	2008		Spring, Maryl	and
alt	permit. Pages Department of I Important: If ite any Injury or o		21. Signature of Funeral Service Licen	see		and Address of Facility CIS J. COL.				
<u> </u>	20 E # 9		danas sa	Joseph	500	University	Blvd. W.	Silver S	Approximate	901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death one cause on each line.	i. Do not enter the ri	lode of dying, such as c	cardiac or respiratory	y arrest,	Interval Between Onset and Dea	
	Physician	1	Immediate Cause (Final disease or condition	a. Pneumonia						
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):				1	
	- Administra	L	Sequentially list conditions,	b. Hypertens Due to (or as a consequence)	on					
	ed sit	Examiner	if any, leading to immediate cause. Enter of chipse Cause (Disease or injury that initiated events			nh Dinanga				
	eecut and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequ		rt Disease				
8760,	cate be executed oblysician and the burial-transit	ᄪ								
387	icate phys s the	dical		α,						
9 X	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna				23d. Date	e of delivery	
Вох	atter for u	ciar	in the past 12 months?	1 ☐Live birth 2 ☐Feta 4 ☐ Pregnant at time of d		c pregnancy (specify)		– Mor	nth Day Yea	ar
P.0.	the d y the ched	ıysi	9 Unknown	9□Unknown					-	_
	requires that the death certific een signed by the attending p nould be detached for use as	F P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyir	ig cause given in Part I.	23e. D	id tobacco use contr	ibute to the cause of deal	th?
Division or Vital Records,	quires n sigr	d by					1	Yes 2 No	3 Probably 4 Wunk	nown
000	> 2 70	Completed					24a. W	vas an 24b. V	Were autopsy findings ava prior to completion of caus	ailable
Re	e r e	E DE					р	erformed?	leath? □Yes 2□No	
g	Iclan; Th certificate ector, pag		25. Was case referred to medical			26. Place	of Death (Check or			
5	Physician; r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 W Nu	rsing Home 5 🗆 F	Residence 6 Oth	er (Specify)	
ō		1: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Descri	be how injury occurr	red	
lon	ndling th. :: Afte	ig	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		M	1 ☐ Yes 2 ☐ 1	No			
/isi	I or Attending after death. Director: Afte	iji.	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At h	ome, farm, street, fac	ctory, office	28f. Location	on (Street and Numb Town, State)	er or Rural Route Numbe	er,
	al or s afte	Certification:	U:				- 1/2			
	Hospital 24 hours (Funeral tely filled	ia C	29a. Certifier 1 ☐ CertifyIng Pl	nysician: To the best of my knominer: On the basis of examina	owledge, death occur	red at the time, date an	nd place, and due to ath occurred at the ti	the cause(s) and ma me, date and place,	anner as stated. and due to the cause(s)	
	n 24 he Fu	edical	one)	and manner stated.						
	To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by the	Σ	29b. Signature and title of certifier	`		29c. License number		250. Date signe	d (Month, Day, Year)	
			thish	- M·D		D30132		4 28	2008	
	30		30. Name and address of person who	completed cause of death (Item	m 23a) (Type, Print)	ne, #101,	Rockvilla	, MD 2085	0	
				32 Registrar's Sign		110, 1100,		, 115 2005		
	St	ate	31. Date filed (Mohth, Day, Year)	ALC:	K Aces	Fa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Me	ental Hygien	ne O O O	
		_	Registrer Certificate of Death	Reg. N	104 UU8	15626
	Physici	an	Tyrence Kuenua Covination		ay Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death	4 19	Ic. County of Deat	0830 M
H	Exami	101	Anna Arundul Medical etc Annapalis		AA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign untry)
Ļ	Director		Usual Residence of Decedent	4-15-6	58	mD
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Many me-f eh	ţō	mr Ann Arundal Annapolis			1 Yes 2 No
	or 28:	Olrec	10e. Street and Number 10f. Zip Code	10g. (Citizen of What Co	untry?
	ath w	Funeral Director	706 C Newtowne Dr 21401		USA	
	item item	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or iteme 23a or 28e-f ehow aumatic event, the Medical Exerciter must be notified at	Ď	1 (2Never Married 2 Married 1 Yes 2 No 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes 2 Yes 1 Yes 2 Yes Ye		Specify:	black
Maryland 21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	Kind of Business/	Industry
2	vithin ne. hen	Jq m	Elementary/Secondary (0-12) College (1-4or 5+)	'	-	
7	Hygie Hygie thert		17. Father's Name (First, Middle, Last) 18. Mother's Name (in the content of the	Eiret Middle Maide	an Cumamal	
au	id be ental ked o	To Be	Terence James Covington St Tibban		gare t	Henson
ary	shou and M mar umat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Making Address (Street and Number or Rural Is			
	of Heelth at Item 27 le		Tibrary Henson/mother 706C Newtown		Anna	les ms
ore	of He of He if Item or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Location - City or	Town, State
altimore,	permit. Pages Depertment of I Important: If Its Imy Injury or o		4 Donation 3 Other (Specify) Metro Crematory 4/28/2	2008 Bal	timore,	MID
Ba	permit. Pages 1 and 2 should Deportment of Heelth and Men Important: If Item 27 ie marke eny Injury or other traumatic <u>once</u> .			lesty Fun		e, P.A.
			12 Ridgely Ave. Annap 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r	olis, MD	21401	Approximate
8	Pnysician		Immediate Cause (Final	oophatory arrost,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a			4 days
	Examiner		Sequentially list conditions, b.			
	od ii	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	s be executed siclen and burial-transit	хап	that initiated events resulting in death) Last Due to (or as a consequence of):			
8760	death certificate be executed e attending physicien and nd for use as the burial-transit	dical E				
9	tificate ng physi as the t	ledi				
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del	
o.		by Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9		Month	Day Year
<u>.</u>	res that the de igned by the a be detached f	Ph.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tohacco	use contribute to	the cause of death?
g	requires that the neen signed by th hould be detache			1 ☐ Yes		obably 4 Dunknown
<u>ဂ</u>	> 11 00 1	olete		24a. Was an	24b. Were au	topsy findings available
ž	e ~ 6	Completed		autopsy performed?	prior to death?	completion of cause of 2 ☐ No
Vital Records,	sicien: Th certilicete rector, pag	Bec	25. Was case referred to medical examiner? 26. Place of Death (4)		10 10 105	2 No
	hys this	၉	1 ☐ Yes 2 1 ☐ No			cify)
Division of	ding P In. After funera	tlon	1 ZNatural 5 Pending (Month, Day Year) Injury Work?	d. Describe how inj	ury occurred	
<u> </u>	r Attendi er death. rector: A i by the fu	flca	3 Suicide 6 Could not be 28e Place of Injury - At home Jarm street factors office 28	f. Location (Street a	and Number or Ri	ral Poute Number
á	el or A s after af Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Sta	ite)	, ar riodio rumber,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in Director C	edlcal (29a. Certifier (Check only only 10 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause((s) and manner as	stated.
	the thin 24 the F	Medi	and mariner stated.			
	S T K	-	29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Monti	n, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	AP	01/19	, 2000
			Sur - ne Rindflesch 201 Med I Pkuu	Annal	nm. 2	2145
	Sta		31. Date filed (Month, Day, Year) 32. Digistrar's Signature	7000	3 . 11	X140,
	Registr	ar	APR 2 8 2008 Show & Back			

		ľ	For State Registrar	State of Ma	aryland		artment of F <i>rtificate of</i>			giene Reg. No.	2000	1 17 60
ļ,	Discontinu		1. Decedent's Name (First, Midd.	le, Last)					2. Date of De	ath	Year	3. Time of Death
	Physicia /Medic		Edith Ruth Co	chrane					April	27 , 2	2008	2:06 P M
	Examin							r Location of Dea	ıth		County of Death	
							Temple 1				nce Geo	0
	Funeral		5. Social Security Number	6. Sex 7. Ag		as <i>t birthd</i> ay, 26 Yrs.	If Under 1 Year Months Days	Hours Min	s. 8. Date of Bir (Month, Da	th ly, Yea <i>r)</i>	9. Birthp	olace (State or Foreign htry) h Carolina
	Director		579-22-1344 Usual Residence of Decedent			36 Yrs.			Sept 1	Z , 19	ZI Nort	n Carolina
	yland iow at		10a. State 10b. County	1	10c. City	, Town or L	ocation				1	0d. Inside City Limits
N C	Mar a-f sh fied	ţo	MD Prince	George's	Temr	ole Hi	11s					1 ☐ Yes 2X No
	or 28;	Director	10e. Street and Number	- 0			10f. Zip Code			10g. Citize	en of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show r must be notified at		4114 Blacksnake	Drive			20748			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of If If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No)- 14	 Race - Americ Black, White, 	
30	be filed within 72 hours after death with the Marylar at Hygiene. At Hygiene, of the Will with than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	If Yes, Give	No		1 ☐ Yes 🎢 No				Specify:	
-0030	tural			nt's Education		16a. Dece	edent's Usual Occup	pation		16b. Kind	d of Business/Inc	
<u> </u>	in 72 in "na Medik	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5	<u>)</u>	(Give life.	kind of work done DO NOT use retire	during most of wo d)	orking			,
7	d with giene er tha the I	E	12	Oollege (1-401 S	,+,	Sales	person			Reta	il Sale	s
and	e filed al Hygie other vent, th	Be	17. Father's Name (First, Middle,	*				18. Mother's Na	ame (First, Middle,	, Maiden S	Surname)	
a	should be and Mental s marked o	10	Sturgeon Malone	Robinson				Bertha	May Ball			
Mar	nd 2 should be Ith and Mental 27 is marked o traumatic eve		19a. Informant's Name/Relations				ing Address <i>(Street</i> Blacksnal					
2	s 1 and 2 sh f Health and Item 27 is m other traum		William F. Coch		looi: Bi	1			-		·- <u>-</u>	
0	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation				osition (Name of matory or other pla		Date		ation - City or To	
Бантто	it. Partment		4 □ Donation 5 □ Other (5		Ches		ce Cremato	1			sville,	
Ö	Depart Impo		Dans G. A	II () He	1010		2. Name and Addre					
fs.	ar.		23a. Part1. Enter the disease, o	r complications that caused	MO12 the death	Do not en	severly L ter the mode of dyi	 Heckro ng, such as cardia 	ac or respiratory a	CLa rrest.	rksvill	e. MD 21029 Approximate Interval Between
-	Physician		Immediate Cause (Final Onset and Death									Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or							(MKrown
	Examiner						act inter	tin			6	17K200-
L		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cons	ence of):	act intec					
	cuted nd ransif	Examiner	that initiated events	o	cube	trun U	len					Unknown
Š	e exe ian al urial-1		resulting in death) Last	Due to (or as	a consequ	ence of):						
0/00,	lificate be executed g physician and as the burial-transit	edical		d								
0	- D 6	_	IF FEMALE:	On Hune auteeme	n(n.c n.c.							
X O O	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	⊒Ectopic pregnanc	у		23	 Date of deliver Month 	ery Day Year
5	the de	ysic	1 ☐ Yes 2 2 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	ain 5	Other (specify) _					
ŗ	that ed by deta		Part II. Other significant conditi	ons contributing to death b	ut not resu	Iting in the u	ınderlying cause giv	ven in Part I.	23e. Did t	obacco us	e contribute to the	he cause of death?
cords,	luires n sign	d by	Diabetin	Melitus a	1760	7 +014	1		10	Yes 2□	No 3 Prob	pably 4 XUnknown
5	w rec	lete	Coment	Melitus a	ilun				24a. Was	an	24b. Were auto	psy findings available
ב	The la te has	Completed		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					auto	psy ormed?	prior to co death?	mpletion of cause of
2	an: J	a	25. Was case referred to medica	ď				26. Place of De	1 Yes eath (Check only o	2 🔀 No	1 ☐ Yes	2 X No
	is cel	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatie	nt 3 DOA Oth		Home 5 Resi		□Other (Specif	·v)
5	ng Ph ter th neral	ü	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time o	of 28c. Inju		28d. Describe			
VISION	endir ath. or: At	atio	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	, , , , ,	,,						
<u> </u>	or Att ter de lirect	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At hou c. <i>(Specify</i>	me, farm, st	reet, factory, office		28f. Location (a City or To	Street and wn, State)	Number or Rura	al Route Number,
ב	ital curs af											
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 ► Certifyi (Check only one) 2 ■ Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examinat	wledge, dea ion and/or i	th occurred at the tinvestigation, in my	me, date and plac opinion, death oc	ce, and due to the curred at the time,	cause(s) a date and	and manner as s place, and due t	itated. o the cause(s)
	o the ithin i	Mec	29b. Signature and title of certifie	er			29c. Licens	se number		29d. Date	signed (Month,	Dav. Year)
	F ≥ F 5) Rut	Enh	11.0		7) 43446			7. 28.0	*
0	10-	-	30. Name and address of person		eath (Item	23a) /Tyme	Print)					
(2	1)00		ROINTAN FA	RAHIFAR !	1.0	9801	Georgia.	Are Suit	1 3-32	Silver	Spring	MO 20902
	Sta		31. Date filed (Month, Day, Year,	32. Registra	ar's Signat	ure	boute				,	
	Registra	ar	APR 3	0 2008 Julia	was	B. 16	boute					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Montk **Physician** 10:40 AM Curry 2008 Wayne Charles 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown 16922 Alcott Road If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Month 1039, 1944 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Maryland 1**▼**M 2□F Months 63 Yrs 465-76-1368 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County and Mental Hygiene. Is marked other than "netural" or Items 23e or 28a-1 show raumatic event, the Madical Examinat mast be maillied at 1 ☐ Yes 2 ▼No Maryland Washington Hagerstown Directo 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21740 USA 16922 Alcott Road Funerai filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Concrete Manufacture Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Smith Pages 1 and 2 should be E11en Mary Warren Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16922 Alcott Road, Hagerstown, MD 21740 f Health aitem 27 I Ella Curry/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gards 5/2/2008 Frederick, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1 Env. the disease, examplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sma months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 3 Probably 4 □Unknown 2 🗌 No icate has been sig , page 2 should b Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2**X** No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Sesidence 6 □Other (Specify) Certification: To 1 🗌 Yes this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death Fo the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. fo the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

5+1

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar 30. Name and address of

who completed cause of death (Item 23a) (Type, Print)

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** MAY 10° 35AM 2 Harold Cain /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner c have 6 eorge 9. Birthplac 27, 1935 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min (Month, Day) 5. Social Security Number **Funeral** MinFebruary Days 251-48-7223 1**☑** M 2□ F 73 Director Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland la or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥¥Yes 2 No Director D.C. Washington 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 4744 Benning Rd. S.E. 20019 #203 U.S.A. "natural", or Items 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1□Yes 2HNo BLACK Specify Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) e College (1-4or 5+) Roofer J.W. Conway marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be and Mental Mary McBride Lucious Cain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07 permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 4744 Benning Rd. Mrs. Maxine J. Cain (Wife) S.E. #203 Wash. D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Mem. Cemetery May 9, 20c. Location - City or Town, State 20a. Method of Disposition 1 Denial 2 □ Cremation 3 □ Removal from State 2008 Suitland, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rollins Funeral Home, 20019 4339 Hunt Pl. N.E. Wash. D.C. and it. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosci entic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached i 9 Unknown signed by the signed of the signed to the signed by the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? X 1 ☐ Yes 2 ☐ Yo 24a Was an has le 2 autopsy page the Hospital or Attending Physician: The certificate 1□ Yes 2 40 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2∏ No 2 R/Outpatient 3□ DOA ို 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

To the Hospital or Attendin
) within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu

State Registrar

31. Date filed (Month, Day, Year) MAY 13

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

SALVADOR

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month 2008^{ear} 9:45 a M Helen Marie Carev 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Northampton Manor Nursing Center Frederick Frederick 9. Birthplace (State or Foreign Country) Mary Land 8. Date of Birth (Month, Day, Year) Aug 7, 1924 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Months Days Hours 219-12-1015 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County Maryland Frederick Frederick 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 East 16th Street 21701 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Sales 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irving Masser Emma Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jeff Storks, Grandson 8013 Dustin Drive, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory May 8,2008 |Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 23a. Part 1. Enter the gisease, or co shock, or heart dilure. List on Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

physician ar s the burial-ti

signed by t I be detach

page certificate I

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician/Medical

Completed by

Be

Medical Certification: To

requires that the death certificate be executed

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Division of Vital Records,

Department of Health a Important: If Item 27 is any Injury or other trainonce.

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be netitied at

is marked other than

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a State

Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury Examiner that initiated events resulting in death) Last

y one cau	Congestive heart Fairure	Interval Between Onset and Death
	Due to (or as a construence of):	
b		
	Due to (or as a consequence of):	
c		
	Due to (or as a consequence of):	
d		
	yes, outcome of pregnancy □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	e of delivery

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

Pregnant at time of death

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 □ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 TYes

25. Was case referred to medical examiner? 1 ☐ Yes ZNo

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation

1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a, Certifie (Check only one)

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

5505, M TITED. V'

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

6 ☐ Could not be

determined

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Thomas Dunn April 23, 3:45 a 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 914 Lamberton Drive
5. Social Security Number 6. Sex If Under Year I II Under 24 Hrs. Mon Egomery 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 → M 2 □ F Months Days Hours 119-20-5552 80 Director June 5, New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rms 23a or 28a-f shu r must be notified a 1 □Yes 257 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 Lamberton Drive 20902 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 No If Yes, Give Aug. 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 1945 1946 ð Aug. Specify: XX Widowed 4 ☐ Divorced Year or Dates: er than "natur, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Market Research/ Elementary/Secondary (0-12) Businessman Personnel Placement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Thomas Joseph Dunn Elsie Doretta Linn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Thomas Dunn, Jr./Son 17105 SW 80th Court, Miami, Florida 33157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State April 27, Metropolitan Crematory 4 Donation 5 Dother (Specify) 2008 Alexandria, Virginia 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 5 Que 23a. Part1. Duter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sacral Decubitus Ulcer Examine Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Mellitus, Hypertension certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 1□ Yes 2 No or Attending Physician: rector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes XX No funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

Jack Epstein, MD

Year)

2008

APR 29

30. Name and address

31. Date filed (Month, Day,

10810 Connecticut Avenue, Kensington, MD 20895

of person who completed cause of death (Item 23a) (Type, Print)

32. Begistrar's Signature

29c. License number

D41245

29d. Date signed (Month, Day, Year)

April 23, 2008

08-03131 Ro

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

ald G. Donov Physicia		State of Maryland / Departme - For State Certifica degistrar 1. Decedent's Name (First, Middle,Last)	te of Death	Reg. N 2. Date of Death	3. Time of Death			
dical Examii		Ronald G. Donoway		Month Da April 22, 2008	16231115			
		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of De Annapolis		4c. County of Death Anne Arundel			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Yrs. If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth(Min. 10/28/1	M/DD/YYYYY) 9. Birthplace (State or Foreign Maryland Country)			
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of			10d. Inside City Limits 1 Yes 2 X No			
rland -f shor	Ď	Maryland Anne Arundel 10e. Street and Number	Annapolis	10g.	Citizen of What Country?			
ne Maryland or 28a-f show any <u>fled at once.</u>	Director	522 Corbin Pkwy.	21401		USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
er death , or ite r must	Funeral	1 Never Married 2 Married 1 X Pes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1958-62	1 Yes 2 X No specify:		Specify: White			
ours aft atural" amine	d by	or Dates:	Decedent's Usual Occupation (Give kind during most of working life, DO NOT use	d of work done 16	b. Kind of Business/Industry			
6 n 72 hc an "n; ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ystems Analyst	,	N.S.A.			
OO3	ome	5+ years S 17. Father's Name (First, Middle, Last)	ystems Analyst 18.Mother's N	Name (First, Middle, Maid				
ral Hy,	Be C	Harry J. Donoway		Elva Ella Pa				
212 nould b d Ment is mark	To E	19a. Informant's Name/Relationship (Type, Print)	o. Mailing Address (Street and Number					
MC at an alth an 27 i	3		811 St. Mary's Rd.	Date 2	Oc. Location - City or Town, State			
ore, ges 1 a t of He : If ite		1 X Burial 2 Cremation 3 Removal from State Park	ory or other place)		Pittsville, Maryland			
Itimit. Pay		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			Calas Funeral Home			
Ba perm Depa Impo injur	d: 1	1. bed llolo	2973 Solomons	Island Rd.,	Edgewater, MD 21037			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		liac or respiratory arrest	, shock, or heart Approximate Intervention Between Onset an Death			
/Medical raminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascu Due to (or as a consequence of):	lar Disease		Deam			
	je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last						
cuted ind transit	Ĕ	UNPENDED AMENDED						
50, te be executed ysician and burial - transi	Medical							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	sician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)						
Bo: Te death the att	Physi	1 Yes 2 No 9 Unknown g Unknown	ng in the underlying cause given in Part	I. 23e. Did toba	acco use contribute to the cause of death?			
P.O. Es that the d gned by the	۾	Part II. Other significant conditions contributing to death but not resulting	.g the underlying educe given in that		2 No 3 Probably 4 Unknow			
ords, P.C. w requires that as been signed to should be deta	Completed			24a. Was an				
of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should	_			perform 1 Y Yes 2	ned? death?			
tal Rection: The certificate ector, page	ပြို့	25. Was case referred to medical	26.Place of Death (C					
of Vital ing Physician: After this certifuneral director,	Ba Ba	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/C			esidence 6 Other:			
	Į į	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	. Time of Injury 28c. Injury at Work?	1	ow injury occurred			
ivisior or Attend after death. Director:	catic	2 Assident Investigation	farm, street, factory, office building, etc		reet and Number or Rural Route Number, C			
Division tal or Attendirurs after death.	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ate)			
Hospital 24 hours : Funeral etely filled	_	29a. Certifier	eath occurred at the time, date and place	ce, and due to the cause	(s) and manner as stated.			
Di To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	uneu at the time, date a	29d. Date signed (Month, Day, Year)			
N.	Ž	29b. Signature and title of certifier	O.C.M.E.		April 23, 2008			
OXY		30. Name and address of person who completed cause of death (Item 23a						
0.10	X	Laron Locke MD. Assistant Medical Examiner 1	, 11 Penn Street, Baltimore, MI	21201				
	State	(1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	beech!					
Regi			DICINAL	<u></u>				
HMH 17 Rev 1.	/2001	OCME	RIGINAL					

08-03479 Carolee L Da

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ar Oi	ee L Dane		State of Maryland / Departi-	cate of Death	Reg. No	2008 1563:
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death Year 2233 hrs
edi	ical Exami	ner	Carolee L. Dane		May 6, 2008	4c. County of Death
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea Frederick	atn	Frederick
			Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last I	M/DD/YYYY) 9. Birthplace (State or		
	Funeral Director		217-44-8497 1 M 2 XF 60	oirthday) If Under 1 Year If Under 24F Months Days Hours Months Days Hours Months Days Hours Months Month	5-27-1	Foreign
	,	F	Usual Residence of Decedent 10a, State 10b, County 10c, City, To	wn or Location		10d. Inside City Limits
	ow any		Total State	rederick		1 Yes 2 X No
0	Maryland 28a-f show d at once.	ま	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	ith the Maryland s 23a or 28a-f sho	Director	1704 Jacob Brunner Drive	21702		USA
	with t ns 23s be not		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
	death or iten	Funeral	Never Married 2 Married 1 Yes 2 X No			Specify: White
	s after ral",	à	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2X No specify: 6a. Decedent's Usual Occupation (Give kind		b. Kind of Business/Industry
	2 hour "natu	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use	retired)	Education
	5-0036 led within 7. Hygiene. other than	ם	6	Teacher		Education
	21215-0036 sold be filed within 72 hours after death with the Maryland homel Hygiens homel Hygiens marked other than "natural", or items 23a or 28a-fish in event, the Medical Examiner must be notified at once to event, the Medical Examiner	ပြ	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid ed Sjorho	
	2121; uld be fil Mental I marked	o Be	Norman LaRochelle 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number		
		۲	Laurence Funk Husband	1704 Jacob Brunne	er Dr Fre	derick, MD 21702
	ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition 20b. Pla	ce of Disposition (Name of cemetery, matory or other place)	Date 20	Oc. Location - City or Town, State
	o		1 Burial 2 Cremation 3 Removal from State Smi	thsburg Crem 5		mithsburg MD
	Baltimore, permit Pages I at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Ligensee	22. Name and Address of Facility K	Keeney & H	Basford P.A.F.H.
			23a. Part I. Enter the disease, or complications that caused the death. D	106 East Churc	ac or respiratory arrest,	derick, MD 21701 shock, or heart Approximate Interval
	Physician Medical		failure. List only one cause on each line.			Between Onset and Death
	-xaminer	1. L	Immediate Cause (Final disease or condition resulting in death) a. Alcohol and Temaze Due to (or as a consequence of):	pem intexication		
			Sequentially list conditions, b			
		iner	if any, leading to immediate Due to (or as a consequence of):			
	it .	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	'60, ate be executed physician and he burial - transit	<u>ज</u>	d.			
	O, e be ex sician burial	Medical	VINPENDED AMENDED, 28a-f, per IF FEMALE: 23c. If yes, outcome of pregna			23d. Date of delivery
	876 tificate ng phy as the	\}	II I CIVE ICC	2 Fetal death 3 Ectopic pr	egnancy	Month Day Year
	ath cer attendi	Sicis	Pregnant at time of deal 1 Yes 2 ✓ No 9 Unknown 9 Unknown	th 5 Other (Specify)		İ
	the de	Physician/	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I		acco use contribute to the cause of death?
	P.O. P.O. ss that gned the deta	≧	•		1Yes	2 No 3 Probably 4 Unknown
	ds, require been si	l se			24a. Was an autopsy	prior to completion of cause of
	e law te has	Completed			perform 1 V Yes 2	
	in: Tl srtifica	B C		26.Place of Death (Cl		
	Vita hysicii this ce	1 P	1 Yes 2 No	ROdipatient 6 2511	ursing Home 5 Re	esidence 6 Other:
	ing P		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 12-4 5 /6 /2000	1 Yes 2 V N		
	Sion Attend death.	Cati	2 Accident Pending Investigation 28e Place of Injury - At ho	FND 9:45 pm A	28f. Location (Str	reet and Number or Rural Route Number, City
	Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) found: r		or Town, Sta 1704 - Jacob	ite) Brunner Dr. Frederick MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and commensary fineral pirector. The property of the proper	cal Ce		e death occurred at the time, date and place	e, and due to the cause arred at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s)
	To the vithing To the	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
			1/0/11/11/11/	O.C.M.E.		May 7, 2008
	a		30. Name and address of person who completed cause of dilath (Item	23a		
	(8)		Zabiullah Ali, M.D. Assistant Medical Examiner	111 Penn Street, Baltimore, MI		
		Stat	87 / V "2 / HI () 2 / 29 http://de.d	" Sperke	OCME	
	Reg	5116	111111 7 0 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margarita Escarfullet April 26,2008 2:12 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 TF 577-78-3829 52 Yrs. Nov. 13, Dominican Republic Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or itame 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 21 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4101 Delancy Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1X Yes 2 No Specify: Dominican Unknown þ 3 Widowed 4 Divorced other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 4 Human Rights Activist Association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be is marked Octavio Escarfullet Ramona Rosario 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 st partment of Heelth and portant: If Itam 27 is n y njury or other traun Briana J. Milton/Daughter 4101 Delancy Drive, Silver Spring, MD 20906 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State May 3, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia Departr Departr Importa any night 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Lasa 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure 2 Months /Medical Due to (or as a consequence of) Examiner Brain_Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner certificate be executed burial-transit Non-Small Cell Lung Cancer 2 years and resulting in death) Last Due to (or as a consequence of): Box 68760 ettending physicien Physician/Medical as the IF FEMALE esn. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.0. this certificate has been signed by the rail director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 HUnknown Status Post Liver Transplant on Supression Therapy, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Autoimmune Hepatitis autopsy performed? 1□ Yes 2 (XNo Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 2 ♣ R/Outpatient 3 ☐ DOA ŏ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After ttending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М 2 Accident investigation the Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide i or To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 d35996 April 27, 2008 Pmo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd, #400, Wheaton, MD 20902 Linda Burrell, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of N	laryland / Dep	artment of Health and N	•	•	TECOM				
			Registrar	Ce	rtificate of Death		g. No UUO	5635				
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
E	/Medic		Elsie M. Edmondo 4a. Facility Name (If not institution, give street and number)	<u> </u>	4b. City, Town, or Location of Death	April 25	4c. County of Death	4:17 P ^M				
44	Examir	ier	Sunrise Assisted Living	,	Annapolis		Anne Arun	de1				
	Funeral		5. Social Security Number 6. Sex 7. A	ige (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign				
160	Director		040-07-2835 1□ M 2□ SF Usual Residence of Decedent	90 Yrs.	Months Days Hours Min.	Dec. 26		e Island				
	ehow dat	L	10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits				
	within 72 hours after death with the Maryland sne. then "naturel", or items 23s or 28s-f show ta Madisal Examirar mast be notified at	by Funeral Director	Maryland Anne Arundel	Edgewate				1 ☐ Yes 2 🛣 No				
	a or	ā	10e. Street and Number 1533 Widows Mite Road		10f. Zip Code 21037	10	g. Citizen of What Cour	ntry?				
	ns 23	era	11. Marital Status 12. Was Deceder	at Ever in U.S. 13.		ecify Yes or No-	USA 14. Race - Americ	an Indian				
စ	or Item	F	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 ₽	? § No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.				
03	ref. c	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates	:	1 ☐ Yes 2 No Specify:		Specify: Whi	te				
5-0	72 h natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation Solve kind of work done during most of work	ing 10	6b. Kind of Business/Inc	dustry				
12	within sne.	ш	Elementary/Secondary (0-12) College (1-4o	r 5+)	DO NOT use retired)	T) 1 - d					
9	Hygie ther art, II	ပိ	12 17. Father's Name (First, Middle, Last)	Loan	Arranger	e (First, Middle, Ma	Banking					
an	ld be ental ked c	To Be	Patrick Maher		Irene R	,						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow are injury or other traumatic event, the Medical Examinating the notified at ADEs.		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or Run		City or Town, State, Zip	Code)				
Σ	and 2 alth a 127 i		Peter M. Edmondo / Son	1533	Widows Mite Rd. E	deewater.	MD 21037					
ore	of He of Harring I tam		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from Stat	20b. Place of Disp	osition (Name of matory or other place)	Date 20	oc. Location - City or To	wn, State				
Ĕ	Pag ment ant: I ury o		4 Donation State (Specify)	Kalas Cre		/08 E	Edgewater, 1	Maryland				
3all	Depart Depart Import eny in		21. Signature Fun ral S A Livense		2. Name and Address of Facility Ge							
	20 = a		23a art1. Epter the disease, or complications that cause		973 Solomons Islan		· · · · · · · · · · · · · · · · · · ·	. 21037 Approximate				
	Physician /Medical Examiner	ner	shock or heart failure. List only one cause on each Inhandiate Cause (Final disease or condition resulting in death) Due to (or a Sequentially list conditions	s a consequence of):	1			Interval Between Onset and Death				
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ca		Ca	Ca	Cal	Cause (Disease or injury that initiated events c.	s a consequence of):				
O. Box	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year				
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.		cco use contribute to th					
900	awre Is bee	Completed	'			24a. Was an	24b. Were auto	psy findings available				
		E				autopsy performe	death?	npletion of cause of				
V Ita	cian: The entificate ha	Be	25. Was case referred to medical examiner?		26. Place of Deat	(Check only one)		20.10				
-	ys is	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat	ient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residen	ce Other (Specify	, Assisting				
Division of	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	27. Manne of Death 28a. Date of In (Month, D	ay Year) 28b. Time o	Work?	28d. Describe how	injury occurred	/				
S	death death stor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	niugu At home form at	M 1 Yes 2 No	201 Lanation (Ctoo						
<u>></u>	after Direction by	ertii	4 Homicide determined 289. Place of it building, 6	njury - At home, farm, st atc. (Specify)	reet, ractory, onice	City or Town,	et and Number or Rura State)	I Houle Number,				
_	To the Hospital or within 24 hours after to the Funeral Dir. completely filled in I		29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge, deat	th occurred at the time, date and place.	and due to the cau	se(s) and manner as st	ated				
	ne Ho ne Fu oletely	edical	(Check only one) 2 Medical Examiner: On the basis and manner s	of examination and/or in	vestigation, in my opinion, death occurr	ed at the time, dat	e and place, and due to	the cause(s)				
	To the Comp	×	29b. Signature and title of certifier		29c. License number	290	I. Date signed (Month,	Day, Year)				
-	1.4				D57028		4/27					
1	Jan.		30. Name and address of person who completed cause of	death (Item 23a) (Type,	dely Ave	Set 5	231, Ar	makes.				
	Sta Registr		APR 2 8 2008	trar's Signature	ndes.		/	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year p^{M} Catherine Farran April 25, 2008 1:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2130 Saranac Street Prince George's Adelphi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 28, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 F Mary land 219-12-3143 86 1922 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 Yes 2 No Director Maryland Adelphi Prince George's 10f. Zip Code 20783 10e. Street and Number 2130 Saranac Street 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be in Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 ⊟ Yes 25∑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify White 2 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home es 1 and 2 should be filed w of Health and Mental Hygier f Item 27 Is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Fink Josephine Tucker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth W. Farran/Son 6711 Old Stonehouse Lane, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot April 28, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2008 Cedar Hill Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) 2 weeks /Medical Due to (or as a consequence of): Examiner Lung Cancer 4 Months Sequentially list conditions, if any, leading to immediate and the series of the serie Due to (or as a consequence of): Examine be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 힏 in the past 12 months?
1 Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 5 autopsy perform certificate 2≰ No 1□ Yes Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 512 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 1 KNatural 5 Pending investigation reral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital o within 24 hours aft To the Funeral Di

State Registrar 31. Date filed (Month, Day, Year)

Linda M. Burrell, MD

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



2730 University Blvd., #400, Wheaton, MD 20902

29c. License number

D35996

29d. Date signed (Month, Day, Year)

April 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:48 am John Sloan Gillespie April 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 250-26-1977 110 M 2□ F 84 Director 12, 1923 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it flew 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or hems 23a or 28a-f show any or other traumatic event, the Muchal Exprimer mat be modified at 10d. Inside City Limits 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9917 Dameron Drive 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♣]Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> Specify: White 3 Widowed 4 Divorced ımk Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Telecommunications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Briggs Andrew Gillespie Nora Harper ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health as Important: If item 27 Is any Injury or other trau 9917 Dameron Drive, Silver Spring, Md 20902 Loretta M. Gillespie/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition April 26 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2008 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner CINS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Exam physician ar the burial-t Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stely filled in by the funeral director, p within 24 hours a

To the Funeral C

completely filled To the

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) APR 28

29b. Signature and title of certifier

32 Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

29d. Date signed (Month, Day, Year)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 15638 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:31 P M April 26, 2008 Howard George Go1tz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown Washington County Hospital Birthplace (State or Foreign Country) if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months **1** M 2□ F 1948 Illinois 15, 59 342-42-8765 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 □No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A. 286 Potomac Heights Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Vietn 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White Vietnam þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Geraldine Seeger George Goltz ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 306 Capistrane Drive, Cary, North Carolina Glenda Goltz Friend 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Metropolitan Crematorium 5/3/08 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signat re of Fin eral Service Ligensee 20872 Kovert Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cardiogenic Shock Due to (or as a consequence of) Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Vear Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 X No 1 ☐ Yes 2□ No 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 26, 2008 D0062515

State Registrar

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Department of Important: If it any injury or o

3altimore, Maryland 21215-0036

ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

8850 Columbia 100 Parkway,

Columbia, Maryland 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

APR 2 9 2008 Signature

Zirvi

Khalid M.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 6:20 a M Doris Louise Horne 2008 April 23, /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 M 2 T F Director 579-28-4780 Nov. 4, 1926 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√2Yes 2 No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6001 34th Avenue 20782 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examines once. Black White etc. 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Neider Helen A. Schemaitat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Edward Horne/Husband 6001 34th Avenue, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State H Burial 2 ☐ Cremation 3 ☐ Removal from State April 28, Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 Ru 12 23a. Part1. Enter the dise 14, or compli. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia, Multi-Infarct 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension, Chronic Obstructive Lung Disease 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed' 2X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA furierai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Pospital or Attending Post hours after death.
Funeral Director: Aller to Certification; 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 April 25, 2008 ass 30. Name and address of peron who completed cause of death (Item 23a) (Type, Print) Ravi Passi, MD 15225 Shady Grove Road, #208, Rockville, MD 20850 31. Date filed (Month, Day, Year)
APR 2 8 2008 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. (2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 8:50 A M April 25, 2008 John F. Haller 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Severna Park 108 Sherburn Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1 X M 2 □ F 076-22-2069 78 Feb. 07,1930 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel Severna Park 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 USA 108 Sherburn Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No if Yes, Give Year or Dates: 1954 1956 1 Never Married 2 Married White 1 ☐ Yes 2 🛛 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Chemical Bank Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Clements Frederick J. Haller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Sherburn Road Severna Park, MD 21146 Linda H. Haller/ wife Apriliate 26, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, Maryland 2008 Metro Crematory 4 □ Donation 5 □ Other (Specify) 21. Signatu Jan I Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Rene 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) -Ung cancer ucar Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical **Examiner**

Physician

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Funeral

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28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
APY 1 25, 2008 29c. License number 29b. Signature and title of certifier DS2830

State Registrar

DHMH 17 Rev 1/2001

gate Road #300, Annapolis, MD 21901

Enu wen MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

anne werner, MD

31. Date filed (Month, Day, Year)
APR 2 8 2008

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100	7	17	1. Decedent's Name (First, Middle, Last)					2. Date of Deatl	1	3. Time of Death			
	Physici /Medic		Loretta Burroughs			April 2	9, 2008	4:00 A M					
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or Location	on of Death		4c. County of Death				
988	1525 to 35	4	Charles County Nur 5. Social Security Number 6. Sex		la una la at hinth da ul	La Plata If Under 1 Year If Und	der 24 Hrs.	9. Data of Birth	Charles	place (State or Foreign			
	Funeral Director			M 2 XF 86	n yrs. last birthday) Yrs.	Months Days Hour	rs Min.	8. Date of Birth (Month, Day, ctober6	Year) 9. Birth Cou ,1921 Washi	place (State or Foreign ntry) ngton D.C.			
	land ow		10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits			
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	or 28,)irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?			
	23a	la	10200 La Plata Ro	ad		20646			United Sta	tes			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28s-1 show are hinjury or other traumatic svent, the Madical Examiner must be notified at 20.5s.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	i	Was Decedent of Hispanic f Yes, specify Cuban, Mexi t ☐ Yes 2√2 No Spec		cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W				
2-0	72 ho	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	dent's Usual Occupation kind of work done during n	nast of workin	ıa İ	16b. Kind of Business/Ir	ndustry			
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1	2 should be f and Mental h is marked of raumatic avs	ို	James Andrew Burro		19b. Mailir	BL ng Address (Street and Nur	anche		City or Town, State, Zi.	p Code)			
	nd 2 ;		Thomas Higdon, Jr.			Box 415 La P				,			
re,	is 1 and 2 of Health item 27 i		20a. Method of Disposition			sition (Name of natory or other place)			20c. Location - City or T	own, State			
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Baltimore,	permit. Page Department of Important: if any injury or giote.	1	21. Signature of Funeral Service License	/ //		Name and Address of Fa	acility Are	hart - Ecl	nols Funera	1 Home, P.A			
	Ang.		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the						Approximate Interval Between			
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P.O. Box	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be delached for use as the buriat-transit				Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of a 1 Live birth 2 [4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year
٦,	that ed b	by Pt	Part II. Other significant conditions con	ributing to death but r	not resulting in the u	nderlying cause given in Pa	art I.	23e. Did tob	acco use contribute to	the cause of death?			
Records,	quires in sign	g pe	Piracie	12 IN	formi	702		1 □ Ye	s 2□No 3□Pro	bably 4 Unknown			
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R	i: The fav icete has	E O						autops perform	prior to co death? I No 1 ☐ Yes	ompletion of cause of			
Vital	ysician: is certifice director, p	Bec	25. Was case referred to medical examiner?			26. PI	lace of Death	(Check only one					
of V	hysic his ce I dire	2	1 ☐ Yes 2 ₩No	ospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Other: 452	Nursing Hon	ne 5 🗆 Reside	nce 6 Other (Speci	fy)			
טע	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work?		8d. Describe ho	w injury occurred				
Sio	tend death tor: t	cat	2 Accident investigation 3 Suicide 6 Could not be			M 1 Yes 2		0()		15			
Division	after after i Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (eet, factory, office	2	City or Town	reet and Number or Rur , State)	ai Houte Number,			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	cian: To the best of ner: On the basis of ex and manner stated	amination and/or in	occurred at the time, date vestigation, in my opinion,	e and place, a death occurre	nd due to the ca id at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)			
	To the within To the comp	Ň	29b. Signature and title of certifier			29c. License numb	er	25	d. Date signed (Month)	Day, Year)			
						D42	509		4/29/8				
9	bbb		30. Name an odress of person who con Mどいれだれナ SM 1)	npleted cause of deat	h (Item 23a) (Type,	Print) OLA LANG	CIA	# 100	MALDOR!	hs			
	Sta		31. Date filed (Month, Day, Year)	32. Pegistrar's		rank s							

State of Maryland / Department of Health and Mental Hygiene

1- State Amend #2, 5-2-08, per FHDR, HCHD in Amend #2, 5-2-08, per FHDR, HCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 26, 2008 Time of Death **Physician** G. HORSEMAN DAMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 HAVE HOPKING BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Aug 15, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F 219-40-6977 1944 Maryland 63 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 6716 Fait Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Itel 1 ☐ Yes 2X☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marvin DeWitt Horseman Mildred Katherine Butler رخ, Mخ. ب-مrmit. Pages 1 and 2 shc. Department of Health and M. Important: if item 27 ا-any Injury or مـــــ. once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Horseman/wife 6716 Fait Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 04/29/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrhythmia **Physician** disease or condition resulting in death) MINS. /Medical Due to (or as a consequence of): Examiner Athero sclerotic Cardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Konute Dout 1739660 4m1 28, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruberte Durt TELECO North Point Rd. haltimore MD am. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar APR 3 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:44 AM 27 2008 April G. Hermenet Leona /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Citizens Care Center Frederick Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 X F New York 93 3, 1914 Director Dec. 064-30-5252 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Frederick Mt. Airy Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21771 4281 Bill Moxley Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Hotel ျှ Jacob Tack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Airy, Maryland 21771 4281 Bill Moxley Road, Mount Elaine <u>Schrader/ Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 Cremation 3 Removal from State Baptist Rural Cemetery 5/1/2008 4 □ Donation 5 □ Other (Specify) Sodus, New York 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland21702 21. Signatu e of Aneral Service Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Domenlia Immediate Cause (Final disease or condition resulting in death) YCARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 X No for 4□Pregnant at time of death 5 Other (specify) P.0. signed by the a Id be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Other: 4 Lursing Home 5 Residence 6 Other (Specify) Hospital: 2X1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes e After this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the Certification: (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature itle of certifier

State Registrar

32. Registra s Signature 31. Date filed (Month, Day, Year) APR 2 9 2008 >

196 TT Dews, FREDERICK, NO 21702 30 Name and address of person who completed cause of death (Item 23a) (Type, Print PLAYE CH BOLANUY, MD 194 TJD

00062223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend Item	23a per dr	.,g88 L	7/16/08/	eath		Reg. No. 200	8 15644
£	Dhysiol	¥	1. Decedent's Name (First, Middle, Last)					2. Date of De. Month	ath Day Year	3. Time of Death
	Physici /Medic		MARY ELIZABETH	HARDY				MAY	6 2008	
2-	Examin		4a. Facility Name (If not institution, give st				Location of Death		4c. County of De	
		30	CHARLES CO.NURS			1			CHARI	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year) 9. B	irthplace (State or Foreign Country)
*	Director		215-64-6213 Usual Residence of Decedent		86 Yrs.			APR.5	,1922 M	ARYLAND
	and w		10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Manyl f ehc	٥	WD GUADIEC		T	7.7				1⊠Yes 2□No
	28a-	Director	MD CHARLES 10e. Street and Number		LA PLAT	10f. Zip Code			10g. Citizen of What (Country?
	Sa or		10200 LA PLATA	DOVD		2064	6		U.S.	Δ
	ne 2:	era		2. Was Decedent Ever	in U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecity Yes or No		nerican Indian,
0	rite Prite	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				Hican, etc.)		nite, etc.
3	within 72 hours after death with the Maryland ene. Then "naturel", or items 23a or 28a-f ehow he Madical Exam her must be notified a		3 ☐Widowed 4 ☐ Divorced	tf Yes, Give Year or Dates:		1 ☐ Yes 2√2 No	Specify:		Specify:	WHITE
ာ က	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa	durina most of work	ing	16b. Kind of Busines	ss/industry
Maryland 21215-0036	men ithin	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)			
5	filed w Hygier Sther th		12		HOME	EMAKER	40 Markada Mara	- (Fire & Adiabatic	AT HOMI	·t
ב ב	tal H d otl	Be	17. Father's Name (First, Middle, Last)	000					Maiden Sumame)	
<u>S</u>	2 should and Mer is marke sumatic	2	PETER NOBLE THO	et Albabillation	.0		DOROTHY			7'- 0-4-1
Z Z	12 sh h and 7 is n raun		19a. Informant's Name/Relationship (Typ	e, Print)	1.53094-030				er, City or Town, State	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelith and Memtal Hygiene. If Heelith and Memtal Hygiene "naturel", or items 23a or 28a-f ehow fem 21 is marked other then "naturel", or items 23a or 28a-f ehow other traumatic event, the Medical Exam her must be notified at		GARY HARDY / SOI		1701 b. Place of Dispo	Q_WHITE	S LANDI	NG RD.	PRABDYWII 20c. Location - City	NE, MD20613 or Town, State
٥	Pages nent of it ant: if ite ary or o		1 Burial 2 □ Cremation 3 □Re	moval from State	cemetery, cre	matory or other plac	1		·	
	t. Pa		4 ☐Donation 5 ☐ Other (Specify)		T. IONA	IUS CEM		The State of the S		r.,MARYLAND
Baltimore,	permit. Pages Department of important: if it eny injury or o		21. Signature of Funeral Service License			. Name and Addres	RA.	YMOND	FUNL.SER	VICE, P. A.
12 ²			23a. Part1. Enter the disease, or complic	ation that caused the						MD 20646 Approximate
			shock, or heart failure. List only one	cause on each line.	Failure	to Thriv	7e	1	11031,	Interval Between Onset and Death
	hysician /Medical		tmmediate Cause (Final disease or condition resulting in death)	*112h	cime	(15)	Almer C	MICA	5	
	Examiner			Due to (or as a cor						
		-	Sequentially list conditions, if any leading to immediate	Due to (or as a con	Depress	sion				
0	ted nsit	nin	if any, leading to immediate disconsequence of as a consequence of: cause. Enter Underlying Cause (Disease or injury							
. i	xecu and al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):					
68/60,	tificate be executed g physician and as the burial-transit									
89	ficate p phy as the	edicai	Ų.							
			IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pre		75			23d. Date of d	lelivery
ň	death a ette d for	icia	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 ☐ I 4 Pregnant at time		□Ectopic pregnancy □ Other (specify)			Month	Day Year
)	t tha	hys	9 ☐ Unknown	9□ Unknown						
7	The law requires that the death cer ate has been signed by the ettendir bage 2 should be detached for use	by Physician/M	Part II. Other significant conditions cont	nbuting to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ğ ·	quire an sig uld b							10	Yes 2□No 3□	Probably 4 DUnknown
Records,	s bee	Completed						24a. Was		autopsy findings available o completion of cause of
ř	The lay te has	EO						perfo	rmed? death	es 2 No
		a	25. Was case referred to medical				26. Place of Deat			
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	spitat: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing Ho	me 5 Resi	dence 6 Other (S)	pecify)
	는 등 등		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injun	y al	28d. Describe I	how injury occurred	
0	Attending in death.	atic	1 Natural 5 Pending 2 Accident Investigation	(,,	, ,,,,,,		Yes 2 □ No			
DIVISION	ar de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp		reet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
<u> </u>	rs aftar al Dire	Cer								
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	cai	(Check only 2 Medical Examine	cian: To the best of my	knowledge, deat	h occurred at the tin	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
:	To the h within 24 To the F complete	Medical	one)	and manner stated.					29d. Date signed (Mo	
ı	o Twit	-	29b. Signature and title of certifier	/	nn	29c. Licens	5545	6	Lou. Date signed (Mo	Ed .
			1. Jun				0070	2	5/8/	08
	2		30. Name and address of person who com						,	
7			Fatima Hussein 31. Date filed (Month, Day, Year)	, M.D. 56	25 All	entown R	RD. Ste.	101 Ca	mp Sprin	gs, MD 2074
	Sta Registr		MAY 1 3 2008	32. Registrar's S	J. April					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTFW/29d per PLYS (879.5/13/08 HS and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BERTHA HOLMES APRIL 23, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 1 Year 11 Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 □ M 2 □ F Months 74 Yrs. JULY 3, 207-26-3777 1933 PENNSYLVANIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show ust be notified at 1 XYes 2 No Director MD PRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Examiner must be 13310 NEW ACADIA LANE #102 20774 UNITED STATES Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify Specify: BLACK ۾ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6yrs REGISTER NURSE PRIVATE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MURPHY McNEIL LULA BELL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RUTH MILLER/NIECE 57 QUINCY PL., N.E. WASHINGTON, D.C. 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dogation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 4/28/08 BELTSVILLE, MD. CAPITOL MORTUARY f Funeral Service License 22. Name and Address of Facility 21. Signa ura 1425 MARYLAND AVE., N.E. WASH., D.C. 20002 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death complications that caused the death. only one cause on each line. nter the mode of dying, such as cardiac or respiratory arrest, Do n Immediate Cause (Final disease or condition resulting in death) Unknow Due to (or as a onsequence of). **Physician** /Medical Examiner Unknow Dreumony Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atten e detached for u in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an autopsy performed? Yes 2 2.No has 1 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral Is 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (*Month*, *Day*, *Year*) 29c. License number 29b. Signature and title of certifier M.0 043446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave suit silversping MD 20902 ROINTAN FARAMFAR M.O Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 13 2008

Registrar

5:31 A M

9. Birthplace (State or Foreign

Black, White, etc.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Washington, D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

7 months

Year

1 ☐ Yes 2 No

(O) W

31. Date filed (Month, Day, Year) State Registrar APR 3 0 2008

30. Name and addiess of person who completed cause of death (Item 23a) (Type, Print)



			For State Registrar		S	tate of	Maryla	nd / Depa	artmen rtificat				fental Hy	giene Reg. No.	008	156	47
	Dhyoisi		Decedent's Name	(First, Midd	e, Last)								2. Date of D	eath Day	Year	3. Time of {	Death
	Physici /Medi		Gordon	Ev	erett		Jos1y	7n	,				Apri1		2008	7:45	рм
	Examir	ner	4a. Facility Name (If								Location of	of Death			unty of Death		
2			Potomac 5. Social Security Nu		y Nurs			s. last birthday)		ockv:	111e	24 Hrs	0. Data of Bi		ontgome		Constitution
	Funeral Director		009-10-8		1 🔯 M		r. Age (III yr	87 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Aug • 0	ay, Year) 0 1021	9. Birth Cour	lace (State or ntry) mont	roreign
	.A.c.		Usual Residence of					07				l	Aug. U.	7, 1720	J VE	MOTIL	
	how		10a. State	10b. County				City, Town or Lo							1	0d. Inside City	
	Ma m-f-	cto	Maryland	Mont	gomer	У		Silver	Sprin	ıg						1 🗌 Yes	2 🙀 No
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow lical Exacilies frough be motified at	by Funeral Director	10e. Street and Num	nber					10f. Zip	Code					of What Cour	•	
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	tems forms	nue	11. Marital Status		1	Amned For		U.S. 13.	Was Deced	dent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0- 14.	Race - Ameni Black, White,		
36	s afte	Z F	1 Never Marrie			Yes, Give	9		1 🗆 Yes	2 X No	Specify:			Sp	ecify:		
21215-0036	hour	ed t		15. Deceder			ites:WWII		dent's Usua	al Occups	ation			16h Kind	Whi of Business/In		
15	n "na	Completed	(Ѕресіі	fy only highe	st grade cor	npleted)		(Give	kind of wo DO NOT us	rk done d	durina mos	t of work	ing	TOD. KING	n Dusiness/in	uusiiy	
212	iene.	E	Elementary/Secon	ndary (0-12)	,	-College (1 5+		Forest	er /	Cons	serva	tion	ist	Bureau	ı of La	nd Mgm	ıt.
b	il Hygie other	Bec	17. Father's Name (/	First, Middle,	Last)						18. Mothe	er's Nam	e (First, Middle				
<u>a</u>	Alenta Alenta rked tic e	To E	Cliff	Eve	rett	,	Jos1yr	1			Mar	ion	R.	Ne	eill		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene 1 them 23 or 28e-f ehov item 27 is marked other than "natural", or Items 23e or 28e-f ehov other traumatic event, Ite Medical Examiner mant be richtlined at	ľ	19a. Informant's Na	me/Relations	hip <i>(Type, I</i>	Print)	-	19b. Maili	ng Address	(Street a	and Numbe	ər or Rur	al Route Numb	er, City or To	wn, State, Zip	Code)	
	1 and Health tem 27 other tr		Camille	Jos1	yn / S	pous					d Roa		20, Si	lver S	ring,	MD 209	104
ore	0 0		20a. Method of Dispo		3 □Remo	val from S		Place of Dispo cemetery, crei	sition (Nan matory or o	ne of ther plac	Θ)		Date	20c. Locati	on - City or To	own, State	
Ë	tant:		4 Donation	5 Other (S	pecify)	,		. Linco								Mary1a	nd
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Fun	eral Service	Licensee	h	A	22	2. Name an	d Addres	s of Facilit	ty S	imple 7	Cribute	9		
ALC:	HUESU		23a. Part1. Enter th	my	wh,	/ WCG	4						, Rocky		Maryla		
			shock, or hear	t failure. List	only one ca	use on ea	ich line.	atin. Do not ent	er the mod	e or aying	g, such as	cardiac	or respiratory a	irrest,		Approximate Interval Betw Onset and D	veen
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	ina:	a			Teller	- h	7	The	riv	<u> </u>				
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39	entifica ling pt e as t	Physician/Med	IF FEMALE:		The Sec			100				300 - 130					
Вох	eath certific attending p	lan/	23b. Was decedent in the past 12 n		1	Live bir	come of preg rth 2 ☐ Fe	tal death 3[Ectopic pr					23d.	Date of delive Month		ear
0	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			I∐Pregna ∃□ Unknov	int at time of wn	death 5	Other (sp	ecify)						54,	
۵.	that the by detact		Part II. Other signific	cant conditie	ons contribu	iting to dea	ath but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did	tobacco use	contribute to the	ne cause of de	eath?
Sp.	uires sign ld be	d by	(Vosk	ziti	C	A		, ,	J			1 🗆	Yes 2□N	o 3 Prob	ably 4 🛣 U	nknown
00	w requir been s should	iete	•	C 01	2120	1	1/000	cule	01		~		24a. Was	an 2	4h Were auto	psy findings a	
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<u>></u>	S S	To B	examiner?	No	Hospi	tal: 1 □ In	patient 2[☐ ER/Outpatier	nt 3 DC	Othe	1/		me 5□Res		Other (Specif	v)	
	ding Ph h. After th funeral		27. Manner of Death			Ba. Date of	f Injury n, Day Year)	28b. Time of		8c. Injury Work	at		28d. Describe				
<u>Si</u>	Attending r death. ector: After by the funer	atic	2 Accident	5 Pendir investi	gation	(**************************************	,,,	,,	M		Yes 2□	No					
Division	ial or Attendii s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ		Be. Place o buildin	of Injury - At g, etc. (Spec	home, farm, str	eet, factory	, office			28f. Location (City or To	(Street and Ni wn, State)	umber or Rura	I Route Numb)er,
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	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the completely filled in the completely filled in the complete of the co	Med	29b. Signature and	itle cetifie	,	and manne	or stateu.		290	. License	number			29d. Date si	gned (Month,	Day, Year)	
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l	>		30. Name and addre	ss of person	who comple	ted cause	of death (Its	em 23a) (Tyne	Print)	10	003	, ,	, 1	1-	いいず	0	
			Ahmed He					t Jeffe		Stre	et. F	Rock	ville.	MD 208	55		
	Sta		31. Date filed (Month	Day Year)			gistrar's Sign				, 1		,		<i></i>		
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State of Maryland / Department of Health and Mental Hygiene

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		1 - State Registrar			(Cer	tificate of l	Death	•		Reg. No.	2000		1040
11/1/12		1. Decedent's Name (First, Middl								2. Date of De		y _o Year		Time of Death
Physici /Medic		Christine M. Jo	hnson							^{Month} 23	/200	8		7:45pm м
Examin		4a. Facility Name (If not institution		umber)			4b. City, Town, or					County of Dea		1
		Mandrin Hospice		T				wood				Anne Ar		
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (II	n yrs. last birth 41 Y		If Under 1 Year Months Days	Hours	Min.	8. Date of Bir (Month, Da 1/7/19	rth ay, Year)	(ear) 9. Birthplace (State or Foreign Country) DC		
Director		219-98-1346 Usual Residence of Decedent				13.				1///19	07		טע	
and w		10a. State 10b. County		10	c. City, Town	or Loc	ation						10d. I	nside City Limits
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ms 2	Funeral	11. Marital Status	12. Was De		r in U.S.	13. V	Vas Decedent of H Yes, specify Cuba			cify Yes or No)-	14. Race - Am		ndian,
or ite		1 ☐ Never Married 2 ☐ Mar	ried 1 ☐ Yes	2171No						Hican, etc.)		Black, Whi	te, etc. Whi	to
ral', c	b	3 ☐ Widowed 🏕 Divorced	If Yes, 0 Year or	Dates:		. 1	∐Yes 2√21√1No	Specify	:			Specify:	MIIT	
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y lould Mer marke	2	Walter R. Johns	* * *		101		A.I.I. (0)		,		- 0"		7: 0	
VICAL 12 sh h and 7 Is m traum		19a. Informant's Name/Relations Penny Sandrock	Mother				g Address <i>(Street)</i> illets Bi			Camde				de)
Then 1 and Healt then 2		20a. Method of Disposition		1			sition (Name of			Date	20c. Lo	ocation - City o	Town.	State
ages nt of .: Fit		1 ☐ Burial 2★ Cremation			cemetery	, c <i>rem</i>	nato <i>ry</i> o <i>r other pl</i> ac ematory		4/26	/2008				
mit. Pages partment of cortant; If it or cortant; If it if injury or ce.		4 ☐ Donation 5 ☐ Other (S		1	Mecro			- ;				timore,		
Dermi Depart Impor any ir		11.				22. Name and Address of Facility Hardesty Funeral Hor 12 Ridgely Ave. Annapolis, MD 2140							-	1 • A •
		23a. Part1. Enter the disease, o	r complications that	t caused the	e death. Do no								Ap	proximate
D lancistan		shock, or heart failure. List Immediate Cause (Final	t only one cause on	-		-	010.0						On	erval Between set and Death
Physician /Medical		disease or condition resulting in death)	a. Due t	1	ast onsequence of		ancev						5	mostus
Examiner			Due	o (or as a co	onsequence o	1).								
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uted d ansit	Examiner	Cause (Disease or injury that initiated events	S .											
execting an an an riaf-tr	Exa	resulting in death) Last	Due t	o (or as a co	onsequence o	f):								
The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Medical		d										ļ	
ng ph	Med	IF FEMALE:												
tendi		23b. Was decedent pregnant	23c. If yes, o		pregnancy □Fetal death	3□	Ectopic pregnancy	/				23d. Date of do Month	elivery Day	/ Year
e dea he at he df	sici	in the past 12 honths? 1 □ Yes 2 Û No 9 □ Unknown	4□Pre 9□Unl	gnant at tim known	ne of death	5	Other (specify)					WOITH	Day	Ισαι
d by t	Physician	Part II. Other significant conditi	ione contributing to	doath but n	ot resulting in	the un	dorlylna causo aiv	on in Part	1	23e Did	tobaccou	use contribute	to the co	ause of death?
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VII.	Be	25. Was case referred to medica examiner?	Hospital:				Oth	or:		n (Check only		~ Man	din	Hospice
aldi B	: To	1 ☐ Yes 2 No 27. Manner of Death	1	Inpatient te of Injury	2 ER/Out		28c. Injur	4 L N		me 5 ☐ Res 28d. Describe		6 Other (Sp	ecify) .	MODISC
ding h. Afte	tion	1 Natural 5 ☐ Pendi		onth, Day Y	iea <i>r)</i> In	jury	Wor	rk? Yes 2[,			
Atter deal	fica	3 ☐ Suicide 6 ☐ Could	nined 200. Pla	ce of injury	- At home, far	m, stre	eet, factory, office					nd Number or I	Rural Ro	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	4 ☐ Homicide determ	bui	lding, etc. (Specity)					City or To	own, State	e)		
ospit hours unera ly fille		29a. Certifier 1 Certifyl (Check only 2 Medical	ng Physician: To t	he best of n	ny knowledge,	death	occurred at the tip	me, date a	and place,	and due to the	e cause(s	and manner	as state	d.
he Ho in 24 he Fi plete	Medical	one)		anner stated		VOI III			sairi occur	- I I I I I I I I I I I I I I I I I I I	, uate an	eu piace, aliu ui	je to trie	e cause(s)
To 1 With To 1	M	29b. Signature and title of certific	er				29c. Licens	e number	20			ate signed (Mor		
Ruch	1	Jeumi	un									71241		
ACO)		30. Name and address of person	who completed ca	use of deat	h (Item 23a) (1	Type, I	Print)	11.1.1	£2	4	!	18 11	1 2	161.1
K		21 Date filed (Month Day You	vne, M.	Washington .	1 (U 150	۲۷	gar R	oud 4	رين	MAIL	apol	(3, 1011.	, ,	- 70/
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riegisti	-61	711112	<u> </u>	-	- 70	17								

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MARTIN, L **Physician** JONES 11:50P M April 20 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 203 Miles River Ct. Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 12 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days 1√2 M 2□ F 65 Yrs. 262-68-4830 Aug 1942 Georgia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2X No Odenton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Miles River Ct. 21113 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Nio Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Electronic Operations Chief 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Bouver Lillie R. Jones 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne M. Jones(Wife) 203 Miles River Ct. Odenton, Md. 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 4-28-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wanname a a come of the forms Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Lamy B. Reese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death PROSTATE Immediate Cause (Final CARCINOMA Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed?

1 Yes 2 No ospital or Attending Physician; Thours after death.

uneral Director; After this certificate if filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051946 APRIL, 23,2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) ROBERTO PILI M.D. JOHNS HOPHINS HOSPITAL, N. 401 BROADWAY BALTIMORE HIP 21231 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State APR 2 8 2008 Straw & Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 1 Year 09: 33 AM Ralph Norman Johnson, Jr. 25 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1XM 2□ F 65 047-32-5681 March 1, 1943 | Vermont Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland | Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 6402 Suicide Bridge Road 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? 1960 1 Mayes 2 □ No 1 Yes, Give 1963 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Truck Driver Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Norman Johnson, Sr. Helen Greenwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy R. Johnson/Wife 6402 Suicide Bridge Road, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 4/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Beulah, Maryland Zeller Funeral Home, P. O. Box 207 21. Sign tupe of Funeral Service 106 Main Street, East New Market, MD 21631 Approximate Interval Between Onset and Death Part1. Enter the disease, or conshock, or heart failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque ce of) 48 years Sequentially list conditions, if any leading to him detections. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

(Check only one) 29b. Signature and title of certifier

29a. Certifier

31. Date filed (Mor

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

April 25, 2008

ne and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f stedical Examiner must be notified

other traumatic event, the Medical

Baltimore, Maryland 21215-0036

should be

Department of Health Important: If item 2 any injury or other once.

Physician

/Medical

Examiner

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Records,

or Vital

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To the Hospital or Attending

within 24 hours after death.

To the Funeral Director: of completely filled in by the f

requires that the death certificate be

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:01 A^M 27 April 2008 Mary Junkins Jane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glade Valley Center Walkersville Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛪 F March 14, 1922 Pennsylvania 86 187-12-8326 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21771 4407 Highboro Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Optometry Office Offive Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Frosch မ Harry Tomlinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun 4407 Highboro Drive Mt. Airy, Maryland 21771 Linda A. Junkins / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery May 1, 2008 Mt. Airy, Maryland 21. Sign vure of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) ementia Immediate Cause (Final disease or condition resulting in death) YCARS **Physician** /Medical Due to (or as a consequence of): Fai live Examiner WCCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertorm 1 2 🕅 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 □ Yes 2 □ No after death. 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hou

To the Fune

completely fi To the 29b. Signature and 29d. Date signed (Month, Day, Year) df certifier

State Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRIMAREEY BOCARUM, 70 19475 BOCARUM, 70 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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1927 J DEWE FREDENICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 0956 M 04 2008 EOTAE =dward /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Nicomico eninsula egional Medical Center 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 212-56-1180 Days 1**X** M 2□ F 56 Months Hours MD 1951 Director Usual Residence of Decedent death with the Maryland 10a. State 10e: City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at MD1 ☐ Yes 2 No Director omerset rincess 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 Funeral JEVIISAlam 'natural', or items dical Examiner ma 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: **b**lack Completed by 3 ☐ Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of Maryland Elementary/Secondary (0-12) Coilege (1-4or 5+) Leeper Shipping + RECEIVING Easton 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Sones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11055 Jerusulem RD. Vrincess. MD 21853 VancssA Jones -20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State Cremotory 05-03-2008 Jalisbury, 4 ☐ Donation 5 ☐ Other (Specify) Sal:sburg 22. Name and Address of Facility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee Princes Anne 40 21858 Atturner C. Walder. 30639 Hampder Ave. Vr. nass-shock, or heart failure. List only one cause on each line. Hampden Ave Immediate Cause (Final (Drona-10 moti **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No Was a... autopsy performed? Ves 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 R/Outpatient 3□ DOA မှ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/25/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		-	30. Name and address of persor	n who completed cause of	death (Item 23s	1)					L		
				Assistant Medical Ex		•	Street, Balt	impre, Mi	2120	1			
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	Funeral Director		5. Social Security Number 6. Sex 18 M 2	7. Age (In yrs	. last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Hrs. 8	3. Date of Birl (Month, Da June 13	y, Year)	Col	nplace (State or Foreign untry) ict of Columbia
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the McAcal Examiner must be notified at once.	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in Used Forces? Yes 2 Nos, Give or Dates:	1	Was Dece If Yes, spe 1 ☐ Yes		spanic Origir n, Mexican, I Specify:	n? (Speci Puerto Ri	ify Yes or No ican, etc.)		. Race - Amer Black, White pecify:	e, etc.
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			30. Name and address Common who completed Kashif A. Firozvi, M.D.,	2101 Medic	al Park	Drive,	Suite	e 200, S	Silve	r Spring	g, Mary	1and 209	902
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

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ပ္	John M. Morris	Willis H								
	19a. Informant's Name/Relationship (Type. Print) Jeremy J. Morris/Son							r Town, State, Zip 803 Oder	^{Code)} 21113 iton, MD	
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	20b. Place of cemeters			110.	ril 25,		ocation - City or To ltimore,		
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	21. Signature of Funeral Service Licensee		Barr 495	ne and Addres anco & Gov. Ri	Sons, Internet	A. Sev	verna	Park Fu	neral Home	
	23a. Part1. Enter the disease, or complications that cause	ed the death. Do n				_		Larry	Approximate Interval Between	
	shock, or heart failure. List only one cause on each Immediate Cause (Final		n	a Cal	10.00.10	CO111 4	1 2	SEAC	Onset and Death	
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ပိ						1 □Yes	2 No		2 □ No	
	25. Was case referred to medical examiner? 1☑Yes 2☐No Hospital: 1☐Inpa			Othe	r:	eath (Check only				
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fica	e Could set be	njury - At home, far etc. <i>(Specify)</i>	m, street, fa					d Number or Rura	al Route Number,	
Certi	4 ☐ Homicide determined building, €	etc. (Specify)			City or To	wn, State)			
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the besing the property of the desired property of the property of	of examination and								
Š	29b. Signature and title of certifier			29c. License			29d. Da	te signed (Month,	Day, Year)	
	(elevel M)			D	3199	+		4/23/0	8	
	30. Name and address of person who completed cause of	death (Item 23a) (Type, Print)	Kuy 8!	-100 A	NNAAL	5 1	u) 219	foi	
te	31. Date filed (Month, Day, Year) 32 Regis	trar's Signature		J		4. 5			, ,	
ar	APR 2 5 2008	trar's Signature	Local							
001	7									

State of Maryland / Department of Health and Mental Hygiene 🔠 🕕 🕃 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Harry E. Matthews, Jr. 9:00 PM April 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 230 Obrecht Road Millersville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑** M 2□ F 79 217-24-7840 Maryland Director Dec. 16,1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Anne Arundel Millersville 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 230 Obrecht Road 21108 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 1948 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer 12 Printing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Schwartz Harry E. Matthews, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Obrecht Road Millersville, MD 21108 Ellen Jane Matthews/ wife April 28, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. St. John's Cemetery Ellicott City, MD 2008 4 Donation 5 Dother (Specify) 21. Signature of Euneral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NOUS /Medical Due t (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Part II. Other significant conditions cogtributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**0** No 1 🗀 Yes 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred ledical Certification: 5 Pending investigation 1 atural 1 🗌 Yes 2 🗌 No 2 Accident I Director: d in by the f 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🕠 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) e and title of certifier rans Hwy Millers ville MI) 2/108

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**½** M 2□ F 1943 Washington DC 20, Director 220 40 4469 65 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location sa or 28a-f show t be notified at 1 ☐ Yes 2 No Directo MD Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21133 United States items 23a ner must b 4 Sheraton Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2**X** No 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 Widowed 4 Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event; the Monee. Owner/Auto Mechanic Gas Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Gilbert McCarthy Beatrice Margaret Leduc ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Sheraton Rd Randallstown, MD 21133 Marie J. McCarthy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 5-1-2008 Bladensburg, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Den 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner (ran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consed ence of) Examine Hospital or Attending Physician: The law requires that the ceath certificate be executed and attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) I ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an autopsy 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar

58.6

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapathi

201-109

32. Registra Signature

29c. License number

D 30641

29d. Date signed (Month, Day, Year)

Back River neck Road Balhmers Maryland 2122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - Famend #10e Per FH G879 5/29/08 JH Certif	ment of He ficate of E	ealth and M Death	lental Hygi Re	ene 9. No. 2008	3 15658
1	Physicia	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	/Medic	al	ELOISE B. McGUFFIN	h City Town or	Location of Death	April 24	4c. County of Dea	2:20 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Glade Valley Nursing & Rehabilitation				Freder	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 Ri	rthplace (State or Foreign country)
	Director		247-20-0600 1□M 2\XF 85 Yrs. M	lonths Days	Hours Min.	AUG. 01,		Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on				10d. Inside City Limits
	Maryla f sho ied at	ō	Maryland Frederick Buckeyst	own				1 □Yes 2X No
	r 28a- notif	Director	10e. Street and Number 3036	10f. Zip Code		10	og. Citizen of What C	country?
	th with		3686 Buckeystown Pike	21717		1	United St	ates
	r dear	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was If Ye	s Decedent of His es, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
30	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ S ☐ Widowed 4 ☐ Divorced Year or Dates:	Yes 2∏ No	Specify:		Specify: W	hite
5-0036	tural		15 Decedent's Education 16a Decedent	t's Usual Occupa	ation	1,	 16b. Kind of Business	s/Industry
212 2	hin 72 In "na Medic	Completed	(Specify only highest grade completed) (Give kind life. DO I life.	d of work done d NOT use retired)	uring most of work Salon	ing		
77	d with	原	12 Hair	dresse	· OWITEI		Beauty Sa	llon
D D	be file d oth event	Be	17. Father's Name (First, Middle, Last) Merwin Bumbarger		18. Mother's Name Eva	e (First, Middle, N	Maiden Surname) Godbold	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	၉		Address (Street a		al Pauta Numbar	City or Town, State,	Zin Cada)
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Ē	Page nent o nt: If iry or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill			1/2008 N	Marion, S.	Carolina
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Licensee 22. No	ame and Addres	s of Facility Sta	uffer Fu	uneral Hom	nes, P.A.
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סר	g Phy ter this neral o	-	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury Work			ow injury occurred	Cony
200	endin sath. or: Af he fur	atio	2 Accident investigation		Yes 2□No			
DIVISION	or Att fter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury At home, farm, street, building, etc. (Specify)	, factory, office		28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
_	pital ours a ieral f		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death or	ccurred at the tim	ne, date and place.	and due to the ca	ause(s) and manner	as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investant and manner stated.					
	To the within To the Comp	M	29b. Signature and title of certifier	29c. License			9d. Date signed (Mor	
)			Anow y mays, mil	D 00	55061	1	April 24,	2000
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Aubrile J. Nagy, MP / 300 W.		. / Frede	erick . N	Maryland 2	1702
	Sta		31. Date filed (Month, Day, Year) 32. Registrate Signature				2	
	Registr	ar	APR 2 9 2008 > Resaure &	KE SER				

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State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan		artment of H		- '	giene Reg. No. 2	008	15659
ķ»			Registrar 1. Decedent's Name (First, Middle, Las)	00,	imodio or i		2. Date of Dea	ath	000	3. Time of Death
ı.	Physici		Parker Wilkinson McC	lellan				May 4,	2008	Y <i>e</i> ar	6:45 P M
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death			nty of Death	0.13
			13541 Osprey Lane			Dowel	1		Calv	ert C	ounty
	Funeral		Social Security Number 6. Se	VIII OFF		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	v, Year)	9. Birth	place (State or Foreign ntry)
0	Director	9	244-60-7932	^{4™ 2⊔ +} 76	Yrs.			April 1		New!	Jersey
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
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	the 28a	Directo	10e. Street and Number	1 20,		10f. Zip Code			10g. Citizen o	of What Cou	ntry?
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	be flied within 72 hours after death with the Maryland the Hygiene. All Hygiene. do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. R	ace - Americ	
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an	ild be lental ked o	To Be	Edward Wheldon M	cClellan			Barbara	a Otis W	Iilkins	on	
Maryland 21215-0036	2 should be filed w n and Mental Hygie Is marked other t raumatic event, th		19a. Informant's Name/Relationship (7	vpe. Print)	19b. Mailin	ng Address (Street	and Number or Rui				o Code)
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Bail	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licen:	see		2. Name and Addre	IX	ausch Fund	eral Hom	e, P.A.	
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o,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):						
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o.	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5L	Other (specify)					
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		Be C	25. Was case referred to medical				26. Place of Deat			1 163	28(110
_ <	Physic rthis ce ral direc	To E	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho	ome 5~ Resid	dence 6 🗆 0	Other (Speci	f(y)
0	ding Pt a. After tt funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur Wor	y at k?	28d. Describe h	now injury occ	urred	
20	Attendi death. ctor: A y the fu	satic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division or	l or Attend after death. Director: /	Certification:	4 Homicide determined	28e. Place of injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (8 City or Tov	Street and Nu vn, State)	nber or Run	al Route Number,
	lospital or I hours after uneral Dir ely filled in t		29a. Certifier 14 Certifying Phy	vsiclan: To the best of my kno	wledge death	h occurred at the tir	me date and place	and due to the	cause(s) and	manner as	etated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		iner: On the basis of examina and manner stated.							
	Fo the Mithin Fo the Comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
			Dand !	Torcho MD		DYT	7610		May	5	2008
•			30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type,	Print)					
			David J. Tardio, MD			310, Prince	Frederick,	, MD 20678	3		
4	Sta	te	31. Date filed (Month, Day, Year)	32 Aegistrar's Signa	ture &	autes					

	1- State of Maryland / Department of Health and Mental State of Maryland / Department of Health and Mental Certificate of Death	tal Hygiene
Physician /Medical Examiner	Virginia Elizabeth Matthews Ma	ate of Death North Day Year 3. Time of Death 9:27 P M 4c. County of Death
Funeral Director	18800 Cooper Road Parkton	Baltimore ate of Birth Worth, Day, Year) ne 9, 1937 Baltimore 9. Birthplace (State or Foreign Country) Pennsylvania
Maryland e-f show life d at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2ऄ No
auth with the Marylan s 23e or 28e f show that be nutified at stall Director	MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 21120	10g. Citizen of What Country? U.S.A.
5-0036 72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Eventual be notified at etech by Funeral Director	T8800 COOPET ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates: 1 Yes 2 No Specify:	/es or No- ,, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
2121 I within piene. r than " Ire Me	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) The secondary (0-12) College (1-4or 5+) The secondary (0-12) College (1-4or 5+) Homemaker	16b. Kind of Business/Industry Own Home
laryland 2 2 should be filed and Mental Hyg 1s marked othe aumatic event, To Be C	u 17. Father's Name (First, Middle, Last) 18. Mother's Name (First	it, Middle, Maiden Sumame) McCleary Ite Number, City or Town, State, Zip Code)
4 a a a	Darlene Hurley 4594 Faraway Dr., Fe 20a. Method of Disposition 1 \text{MBurial 2 Crove Mail 12 decembers} 3 Removal from State 20b. Place of Disposition (Name of Pine and Power May 13)	elton, PA 17322 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If Item any injury or othe once.	Hethodist Cemetery 2008 22. Name and Address of Facility J. J.	Parkton,MD Hartenstein Mortuary,Inc. W Freedom,PA 17349
8760, sate be executed sate be executed sate but sate and sate but sate and sate sate sate sate sate sate sate sate		Interval Between
Geath certific e attending per for use as		23d. Date of delivery Month Day Year
	Part ii. Other significant conditions continuoung to death out not resulting in the underlying cause given in Part i.	3e. Did tobacco use contribute to the cause of deau? 1 □ Yes 2 □ No 3 □ Probably 4 ᠒ Unknown
VITAI HECOND Ician: The law requir certificate has been s rector, page 2 should BE Completed		4a. Was an autopsy autopsy findings available prior to completion of cause of death? Yes 2000 1 Yes 2 No
IVISION OF Or Attending Phys frer death. Director: After this on by the funeral di rtification; To	examiner? O 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	Describe how injury occurred Cocation (Street and Number or Rural Route Number, ity or Town, State)
To the Hospital or within 24 hours afte To the Funerel Dir completely filled in Medical Cerr	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and du and manner stated.	ue to the cause(s) and manner as stated, the time, date and place, and due to the cause(s) 29d. Date şigned (Month, Day, Year)
7	> Celling D22557	5/8/08
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e 100, Mankton, MD 21111

nomas L Morri		State of Maryland / Department of H 1-For State Certificate of Description			. No.	
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Medical Exami ৺	ner	Thomas L. Morrison		May 7, 200	8 ´	1432 hrs
			ity, Town, or Location of Dea a Plata	ith	4c. County of Deat Charles	n
Funeral			Under 1 Year If Under 24H	lrs. 8. Date of Birth		rthplace (State or Foreign
Director		034-30-5096 * M 2 F 66 Yrs.	nonths Days Hours M			ountry) assachusett
		Usual Residence of Decedent		1400.5	0,1041 148	
w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 No
daryland 28a-f show datonce.	to	MD Charles La Plata 10e. Street and Number 10	f. Zip Code		g. Citizen of What Cou	
e Mar or 28s	Director		·	10	J. Citizen of What Col	unity?
death with the Mary/and or items 23a or 28a-f sho must be notified at once.		5321 Lily Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	20646 cedent of Hispanic Origin? (Specify Yes or No-	U S A 14. Race - Ame	rican Indian, Black,
death r item nust b	Funeral		pecify Cuban, Mexican, Puer		White, etc.	
after	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 5.9 – 6.4	No specify:			hite
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	sual Occupation (Give kind of f working life. DO NOT use re	of work done etired)	16b. Kind of Business	/Industry
36 hin 72 e. edical	Completed		s Analyst		Wash Gas	& Light
5-0036 lied within 72 hours afte Hygiene. I other than "natural", the Medical Examiner.		17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	Thomas Raymond Morrison		and the second second	Gelineau	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	٢	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad Sheryl Morrison / Daughter 5321	dress (Street and Number of			
		20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date	20c. Location - City of	
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or other p		ay 3,2008	Chaltanh	nam MD
altin nit. P partme portan ury or			and Address of Facility D	avmond F	Cheltenh	rice P A
		21 Signature of Funeral Service Licensee M00641 563!	Washington	n Ave.,I	a Plata,	MD 20646
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the medialure. List only one cause on each line.	ode of dying, such as cardiad	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
	ie	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
= 411	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	 ·			+
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat - transit		d		 		
60, ate be ex hysician e burial	Medical	UNPENDED				
876 tificat ing phy as the	NZ.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal of	eath 3 Ectopic preg	nancy	23d. Date of delive Month	Pry Day Year
Box 6876 death certificat the attending ph	sician/	4 Pregnant at time of death 5 Other	(Specify)			
O. B. trithe de by the	Phys	Part II. Other significant conditions contributing to death but not resulting in the under	riving cause given in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
, P.O. ires that th signed by	Š	<u> </u>	,g -==== g = =		2 No 3 Pr	
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the control of the funeral director.	Completed			24a. Was a		autopsy findings available
eco ne law te has ige 2 sl	dmo			autops perform 1 ✓ Yes 2	ned? death?	
tal Recition: The certificate rector, page	a)	25. Was case referred to medical	26.Place of Death (Chec			2 110
Vita	OB O	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nur	sing Home 5 F	Residence 6 Oth	er:
ion of tending Pheath.	Ë	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOWND: 28b. Time of Injury FOWND: FOUND:		28d. Describe h	ow injury occurred ollision	
Sior Attend death ctor:	턣	2 Accident Investigation May 7, 2008 1342 hrs	1 Yes 2 ✔ No			
Divisipital or At ours after deral Direct filled in by	Certification	3 Suicide 6 Could not be determined (Specify) Local Street	ctory, office building, etc.	or Town, St		Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		4 Homicide (Specify) LoCal Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, a			
To the Hos within 24 hu To the Fun completely	edical	one) 2 Medical Examiner:On the basis of examination and/or investigation, and manner stated.				
F 3 F 8	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	fonth, Day, Year)
		mas 2	O.C.M.E.		May 8, 2008	
11/1		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner	et, Baltimore, MD 212	01		
- 3	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ct, DaimHole, IVID 212			
Regis		MAY 13 2008 Blace & Sparle				
DHMH 17 Rev 1/2	001	ORIGINAL				

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				aryland / i			lealth and M	lental Hy	giene		
			1 = State Registrar		Cer	tificate of	Death		Reg. No.	100	15562
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
b	/Medic		LORENZO EDWARD 4a. Facility Name (If not institution, give street and number)	NELSC	ON	4h City Town o	r Location of Death	Apri	4c. County	2008	_6:39 A [™] _
	Examin	er							1		~ a b
	Funeral		Alice Byrd Tawes Nursing Ho 5. Social Security Number 6. Sex 7. Age	ome e (In yrs. last bii	irthday)	If Under 1 Year		8. Date of Bir	th	9. Birthp	lace (State or Foreign
	Director		215-05-7004 ^{1໘M 2□ F}	93	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 21, 1914	Couin Marvl	
	P.		Usual Residence of Decedent					,0000,002			
	arylar show d at	Ä	10a. State 10b. County	10c. City, Tow	vn or Loc	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Mi 8a-f	Directo	Maryland Somerset			T. e. e	Crisfiel	d			
	a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of		•
	eath	Funeral	26441 Mariners Road 11. Marital Status 12. Was Decedent B	Ever in U.S.	13 V	Vas Decedent of H	21817	ecify Yes or No	- 14. Bac	US e - Americ	
	fter d r iten iner	Fun	Armed Forces?				lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Blac	ck, White,	etc.
3	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by	1 ☐ Never Married 21 Married 1 1 1 Yes 2 ☐ N 3 ☐ Widowed 4 ☐ Divorced Year or Dates: [N	Var II	1	☐ Yes 2☐ No	Specify:		Specif	y: W	hite
5-0036	2 E 3	Completed	15. Decedent's Education (Specify only highest grade completed)		. Deced	ent's Usual Occup	oation during most of work	ina	16b. Kind of B	usiness/Ind	dustry
Z	within iene. than "I	nple	Elementary/Secondary (0-12) College (1-4or 5	+)	life. D	O NOT use retired	during most of work d)				
7	filed w Hygier Ither th		12			Assembly	40 14-16-3-11				facturer
land	eve stable	Be	17. Father's Name (First, Middle, Last) L. Ned Nelson				18. Mother's Name	sterli Sterli		ne)	
Š	should ind Men marke	မှ	19a. Informant's Name/Relationship (Type. Print)	194	h Mailin	n Address (Street	and Number or Rur			Stata Zin	(Code)
Mary	nd 2 sho alth and 27 is m r traum		Marian Tawes Nelson (Wife)	- 1		-	s Road -			. ,	,
ā,	the the		20a. Method of Disposition	20b. Place o	of Dispos	sition (Name of natory or other place	1	Date	20c. Location		
e E	0 0		1XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			/emorial Pa	i i	2008	Crisfie.	1d. M	laryland
altimore,	permit. Page Department I Important: If any injury o		21. Signature of Funeral Service Licensee 1). 41	22	. Name and Addre	ess of Facility BRA	DSHVM &	SONS F	IMEDA	I HOME
ñ	B II D E		Mary Beth Bradshaw-Pruit	ruit	3 اد	06 West i	Main Stre	et – Cr	isfield	, Mar	yland 21817
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do							Approximate Interval Between
Ļ	Physician		Immediate Cause (Final disease or condition	A		VD					Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a	a consequence	of):						
	Lxaiiiiiei	<u>_</u>	Sequentially list conditions, b. Due to (expendent)	a consequence	-f):					_	
	led sit	nine	cause. Enter Underlying	a consequence	oi):						
	executed in and ial-transit	Examiner	that initiated events resulting in death) Last C	a consequence	of):						
9	be icia		d								
20	death certificate e attending phys d for use as the	Physician/Medical									
X Q Q	endin use	M/n	IF FEMALE: 23b. Was decedent pregnant 1□Live birth		h 3	Ectopic pregnance			23d. Da	ite of delive	ery
n	deat e att	sicia	1 Yes 2 No			Other (specify)	у		Mo	onth	Day Year
٦ ک	w requires that the d been signed by the should be detached	Phy	9 Li Unknown					l oo Bill			41.40
Ś	res th signed be d	ρ	Part II. Other significant conditions contributing to death but	ut not resulting i	in the un	iderlying cause giv	en in Part I.	23e. Did t	. 4		he cause of death?
ecord	requi	Completed						''	Yes 2 No	3 FIOL	oably 4 Unknown
ě	e law has b je 2 sh	npl l						24a. Was	osy	Were auto prior to co death?	psy findings available mpletion of cause of
VITAL	iclan: The lav certificate has ector, page 2:		OF Was asserted and the section					1□ Yes	2 No	1 ☐ Yes	2 No
		o Be	25. Was case referred to medical examiner? 1 Yes	nt 2 🗆 ED/O	utnation	t 3 DOA Oth	26. Place of Deat			(2	
ō		一百	27. Manner of Teath 28a. Date of Injur	y 28b.	Time of	28c. Injur			dence 6 Doth		y)
SION	Attending F r death. ector; After by the funera	ation	1 Natural 5 □ Pending (Month, Day 2 □ Accident investigation	r rear)	Injury		Yes 2 □ No				
<u>s</u>	r Atte er dea recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju		arm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numb	ber or Rura	al Route Number,
5	rs after and properties after the properties after	Cer									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical	29a. Certifier (Check only Medical Examiner: On the basis of	examination as	je, death nd/or inv	occurred at the tivestigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)
	thin 2 the orthology	Med	one) and manner sta 29b. Signature and title of certifier	ited.		29c. Licens	se number		29d. Date signe	d (Month.	Day Year)
	F 3 F 8		1 11	en			48098		4/2		
,			30. Name and address of person who completed cause of de	eath (Item 23a)	(Type. F						
3+	1 EB		D. VIJAY KARUMBUNI	ATHAN		201 HAL	LLHIGHU	WAY, C	KISF1E	2 LD,	MD 2817
	Sta		31. Date filed (Month, Day, Year) 32. Regular	ar's Signature	*	Ano. M.					
DH	Registr	- 10	WW. 0 T 5000	- X	1	A CONTRACT					
. uHI		11.1.1			- 40	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 25, 2008 12:54 PM April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1813 Marshall Road Baltimore Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 XM 2 □ F Apr 29, 66 1941 Maryland Director 216-38-3862 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 XNo Examiner must be notified Directo MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 Marshall Road 21222 USA items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces: 1 XI Yes 2 □ No If Yes, Give Year or Dates: 1968-72 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò Specify: White 1 ☐ Yes 2 X No Specify. Completed by 3 ☐ Widowed 4 ▼ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than 12 Electrical Contractor Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Menta em 27 is marked Mildred Hayden John Jacob Otlowsky 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Kenneth W. Harms/step brother 18 Glen Oak Drive East Windsor, NJ 08520 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 04/30/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funera WMO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a confequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9□Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 D No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ☐Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital this After Hospital or Attending death. after death.

Certification: To filled in by the 24 hours a

To the within 2

State Registrar

Medical

oun

and manner stated.

1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

MITHGREEDUC

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BACT. VA HE

31. Date filed (Month, Day, Year)

29b. Signature and title of/certifie

1 Matural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 ☐ Pending investigation

6 ☐ Could not be

APR 3 0 2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 Anna Mae Outten April 26 5:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cambridge Dorchester 1200 Hambrooks Blvd If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗙 F 215-26-5988 Director Dec. 28, 1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Dorchester X□Yes 2□No Cambridge Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Hambrooks Blvd. 21613 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) stripper publishing 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 is marked ott William W. Handley Susie Willey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1200 Hambrooks Blvd, Cambridge, MD Earl J. Outten husband 21613 permit. Pages 1 an Department of Hear Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 4/30/08 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 Man7h disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner PACKENSONS DISPASE End Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listes of Light) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transi Due to (or as a consequence of): Box 68760. attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month 5 Other (specify) signed by the a 1 ☐ Yes 2 Ho 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🚾 o 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 24a. Was an page 2 s autopsy perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Anesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. or Vital Records, Division 6

within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral or To the Hospital

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and andress of person who cop pleted cause of death (Item 23a) (Type, Print) D.O LOIS A. NaR 100

32. Regist

and manner stated.

f's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of W	iai yiai lu / L	Certifica			Memai my	Reg. No. 2	008	15565
	Div. day		1. Decedent's Name (First, Middle	, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic		William Alfı	ed Polk					April		008	2:55P
T.	Examin		4a. Facility Name (If not institution)	4b. Cit	y, Town, o	r Location of Deat			nty of Death	
		0	16917 Longdraf	t Road				hersburg		Mon	tgomer	У
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bir	Month	er 1 Year Days	If Under 24 Hrs Hours Min.		rth ay, Year)	9. Birthpl Count	ace (State or Foreign ry)
	Director		034-32-4841		62	Yrs.			Sept.	14,1945		achusetts
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10	Od. Inside City Limits
	/aryll	ŏ										1 TyYes 2 □ No
	the l	rect	Maryland Montg	omery	Gail	hersbu	ip Code	_		10g Citizen (of What Count	ny?
	with Sa or t be		16917 Longdraf	t Poad				20878				
	ns 2; mus	Funeral Director	11. Marital Status	12. Was Deceden		13. Was Dec		Lispanic Origin? (S an, Mexican, Puer	Specify Yes or No		ited S	
(0	or iter		1 ☐ Never Married 2 ☑ Marri	Armed Forces ed 1 ☑ Yes 2 ☐ If Yes, Give					to Rican, etc.)	В	llack, White, e	etc.
030	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1963-78	1 Ll Yes	2 No	Specify:		Spe	cify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by	15. Decedent (Specify only highes	's Education	16a.	Decedent's Us	ual Occup	ation	rkina	16b. Kind of	Business/Ind	ustry
21	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or				during most of wo				
	filed w Hygier ther the	S	12		A	dminist	rati	ve Clerk			Milita	ry
pu	be fill tall H d out	Be	17. Father's Name (First, Middle,					18. Mother's Nai	me (First, Middle	e, Maiden Surn	iame)	
yla	should be filed ind Mental Hygi marked other umatic event, t	၉	Alfred Pol							Dempse	/	
Maryland	S E S		19a. Informant's Name/Relationsh					and Number or R				Code)
	1 and 2 Health tem 27 l		Karen Forney 20a. Method of Disposition	/ Wife				t Rd. Ga	ithersb			
jor	Pages nent of hand: If ite		1 ☐ Burial 2 【XCremation		cemete	Disposition (Nry, crematory o	r other plac	ce)	Date	20c. Locatio	n - City or Tov	vn, State
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		4 □ Donation 5 □ Other (S)		Ft. Li			tory 4/28	3/2008	Brent	wood, N	<u>1D</u>
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service	Licensee		İ			Simple T			
100			23a Parti Four the decree or	complications that cause	ad the death. Do	11040 F	ockv	ille Pike	e, Rockv	ille, l	MD_ 2085	52 Approximate
			23a. Part1. Env r the discusse, or shock, or/, eart faily re. List Immediate Course (Final						c or respiratory a	irrest,		Interval Between Onset and Death
١,	Physician /Medical		disease or condition resulting in death)		all Cell		ancei	<u> </u>			1	year
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5		-	Sequentially list conditions, if any leading to immediate	b. Due to (or as	s a consequence	of):						
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<u>,</u>	execi n and ial-tra	Exa	resulting in death) Last	Due to (or as	s a consequence	of):						
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68	± 00 €	Medical										
Вох	death ceri e attendin d for use	₹ I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e pf pregnancy 2 Fetal death	3 □Ectopic	200000000			23d. I	Date of delive	у
	0 0 0	Physician//	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 ☐ Other (Month I	Day Year
P.0	The law requires that the de ate has been signed by the a page 2 should be detached	hys	9 ☐ Unknown	9LI OHKHOWH								
S,	res tha igned be be det	by F	Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying	cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to the	e cause of death?
Records,	w require	ed						- ver	10	Yes 2 No	3 ☐ Proba	ably 4XJUnknown
ecc	law r as be 2 sh	ple							24a. Was	an 24	b. Were autop	sy findings available
<u> </u>		Completed							perfe 1□ Yes	ormed?	death?	2 □ No
ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only			
or Vital	is is	P	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Ou	tpatient 3□ I	Oth	er: 4□ Nursing F	lome 5⊠Resi	idence 6 □0	Other (Specify)
0 0			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, D		Time of njury	28c. Injur Wor	y at k?	28d. Describe	how injury occ	urred	
.0	Attending r death. ector: After y the fune	äţ	2 ☐ Accident investig	ation		М	1 🗆	Yes 2 ☐ No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and Zoe. Flace of Ir	jury - At home, fa etc. (Specify)	rm, street, facto	ry, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rural	Route Number,
	spital or Attend ours after death neral Director: / rilled in by the f	8							4			
	동 수 필 등	ledical	29a. Certifier 1 X Certifying (Check only one) 2 Medical I	Physician: To the besexaminer: On the basis	of examination an	e, death occurre d/or investigati	ed at the tir on, in my c	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) and , date and plac	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner s	tated.	12	9c. Licens	e number		29d. Date sig	ned (Month F	Pay Voar)
			· Corod	m Hags	yrtani	\hat{h}	D32				il 21,	
	D+1	-	30. Name and address of person v	who completed cause of	death (Item 33c)	Type Print)						
			Joseph M. Hagge				anta	r Dr. #3	00 Pac	 	MD 30	950
	Sta	te	31. Date filed (Month, Day, Year)	34 Regist	rar's Signature		-	<u> </u>	NOC.	varrie,	mD 20	000
	Registr	ar	APR 29 2	2008	J. J. K	parte						

		1 - For State Registrar		nd / Departm	ent of Health and ate of Death	Mental Hyg		15666
Physic	ian	1. Decedent's Name (First, Middle, Las				2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	Lloyd Albert				April	28 2008	2:20 a.M
Exami	ner	4a. Facility Name (If not institution, give Chesapeake Woo		4b. (Clambasi Jaca	th	4c. County of Death	
Firmer		5. Social Security Number 6. Se		last hirthday) If U	Cambridge Ider 1 Year If Under 24 Hrs	9 Date of Righ	Dorches	
Funeral Director			□M 2□F 94	Yrs. Mon			1913 Mary	place (State or Foreign ntry) 7Land
in the Marylan or 28a-1 show	ctor	10a. State 10b. County 10c 10che		ty, Town or Location	Cambridge		1	0d. Inside City Limits 1X Yes 2 □ No
3 ti ti	Dire	10e. Street and Number		10f	Zip Code	10	g. Citizen of What Cour	itry?
23 ath 6	ral	512 Governors Av			21613		USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-1 show eny injury or other traumatic event, the Madical Examiner must be huilified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWI.]		ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue s 2 X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036 Id 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other than "neturel", or traumatic event, the Medical Exernity	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation fe completed) College (1-4or 5+)		Isual Occupation work done during most of wo Tuse retired)	irking	6b. Kind of Business/Inc	
led v her ti	Ö	5 (Circl Middle 1 - 1)		wat	erman		seafood	<u> </u>
rylanc	To Be	17. Father's Name (First, Middle, Last) Carlton Phillip			Rona T			
and 2 st ealth and m 27 te m		19a. Informant's Name/Relationship (T) Eddie Phillips	son	512 Gov	ess (Street and Number or Recently ernors Ave.,	Cambridge	, MD 21613	
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item: my injury or other miss.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,		Place of Disposition (emetery, crematory rchester M			Oc. Location - City or To Cambridge,	
Balt permit. Depart Import eny in		21. Signature of Funeral Service Licens	99	4	and Address of Facility T		eral Home P MD 21613	.A.
Physician Physician Physician Physician Physician Physician and Physician and Physician and Physician Phys	ical Ex	23a. Pant1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to or as a conseq	egselve uence of): uence of): Failu	A .	e of respiratory arre	Prop.	Approximate Interval Batween Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	Ideath 3 □Ectopi	c pregnancy (specify)		23d. Date of delive Month	ory Day Year
ds, Puires that uires that is signed bid be detailed by		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlyin	g cause given in Part I.		acco use contribute to th	e cause of death?
	Completed					24a. Was an autopsy perform	prior to con	psy findings available appletion of cause of 2 No
f Vital Prysicien: The is certificate director, pag	Φ.	25. Was case referred to medical examiner?	lo enital:		0	ath Check only one		
of Vita Physician: this certifica	<u>۲</u>	1 ☐ Yes 2 XNo	lospital: 1 Inpalient 2 I				ice 6 ☐ Other (Specify	9
Jing Alter	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe hov	v injury occurred	
Division Hospital or Attend 24 hours after deatt Funeral Director: etely filled in by the	Certif	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	<u>'</u>)		City or Town,	· ·	
To the Hospital within 24 hours a To the Funeral completely filled	ledical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurr tion and/or investigat	ed at the time, date and place ion, in my opinion, death occu	, and due to the cau irred at the time, dat	ise(s) and manner as sta e and place, and due to	ated. the cause(s)
To the I within 2 To the I complet	Σ	29b. Signature and title of certifier A A A A A A A A	, MO		29c. License number D 6 3 359		Date signed (Month, L	R
PXI		MAHBUSA	mpleted cause of death (Item	23a) (Type, Print) 5-0-3	WRN ST.	CAMOS	RIDGE.	MD- 21612
Sta Registr	.e	31. Date filed (Month, Day, Year)	32. Red trar's Signat	ture K	di s			

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 29

2008

32 Registrar's Signature

			State of	Maryland / Depa			Mental Hygi	ene	
ı		90	1 - State Registrar	Cei	rtificate of	Death		g. No. 2 U U B	<u>i 5668</u>
	Physici	an	1. Decedent's Name (First, Middle, Last) Jacqueline Marie Parsly				2. Date of Death Month	Day Veer	3. Time of Death
	/Medi		4a. Facility Name (If not institution, give street and number	ner)	4b. City, Town, o	r Location of Dea	April 2	4c. County of Deat	3:30 p ^M
Å.	Examir	ler	Shady Grove Adventist Ho	, , , , , , , , , , , , , , , , , , ,	Rockv		441	Montgome	
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr		9. Birtl	nplace (State or Foreign
Ь	Director		220-70-3168 1 M 2 T F	50 Yrs.	Months Days	Hours Min	Nov. 26	, 1957 Ma	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Manyla f sho ed at	ō		,					1 ☐ Yes 24☐KNo
	the 1 28a- notif	Director	Maryland Montgome 10e. Street and Number	ery Damasc	10f. Zip Code		100	g. Citizen of What Co	ints/?
	h with		12618 Price Distillery	Road	20872			USA	, .
	ems 2	Funeral	11. Marital Status 12. Was Deced	ent Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Amer	
98	filed within 72 hours after death with the Maryland thygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notifled at		1 Never Married 2 Married 1 Yes 2	X No	Tes, specify outs	Specify:	nto nican, etc.)	Black, White	
Ö	hours tural"	od by	3 ☐ Widowed 4 ☑ Divorced Year or Date	es:					
5	in 72 n "na n "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of we	orking	6b. Kind of Business/I	ndustry
212	d with giene er thai	mo	Elementary/Secondary (0-12) College (1-4	or 5+)	maker	,		Own Home	
9	e file al Hyg othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Ma	aiden Surname)	
<u>ya</u>	should be and Mental I see marked or umatic eve	To	John Henry Parsly			Ca	rol Ann S	trasser	
Maryland 21215-0036	and sm sum		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or F	Rural Route Number, (City or Town, State, Z	ip Code)
	1 and 2 Health tem 27 I		John H. Parsly/ Father 20a Method of Disposition	20b. Place of Dispos		boat Way	, Berlin,		
altimore,			1XXBurial 2 ☐ Cremation 3 ☐ Removal from St	comotory area	natory or other plac	' AT	oril 30,	Oc. Location - City or 1	own, State
	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee				8008	Brentwood,	Maryland
ä	Dep Imp any		50-				Funeral I		
			23a. Part1. Enter the dishase, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory arres	t,	ng MD 20901 Approximate
	Physician		Immediate Cause (Final	iac Arrest					Interval Between Onset and Death
	/Medical		resulting in death)	as a consequence of):					
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8/60	icate be executed physician and s the burial-transit	dical B	d						
٥	tificate ig physi as the t	ledi							
X Q Q	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		Ectopic pregnancy			23d. Date of deliv	,
	e dea the at ned fo	sici		t at time of death 5	Other (specify)			Month	Day Year
J.	that the		Part II. Other significant conditions contributing to deat	h but not resulting in the un	derlying cause give	on in Part I	23a Did toha	cco use contribute to	the cause of death?
g,	uires signe d be	d by		bar not roodking in the dir	denying dadde give	or are are i.			bably 4 💆 Unknown
Hecord	law req as beer 2 shou	lete					24a. Was an		
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VII	ian: rtifica tor, p	BeC	25. Was case referred to medical			26. Place of De	1 Yes 2 ath (Check only one)	No 1 ☐ Yes	2 □ No
	Physician: rthis certific	P C	examiner? 1 ☐ Yes 2 ☎ No Hospital: 1 ☐ Inp	atient 2 ☐ ER/Outpatient	3™ DOA Othe) P.		ce 6 ☐Other (Spec	ifv)
п 0г	ding PI		27. Manner of Death XIN Natural 5 □ Pending (Month,	Injury 28b. Time of Injury	28c. Injury Work		28d. Describe how		.,,
<u>2</u>	Attending r death. ector: After by the fune	cati	2 Accident investigation			Yes 2 □ No			
UNISION	or Al	Certification:	4 Homicide determined 28e. Place of building.	injury - At home, farm, stre , etc. <i>(Specify)</i>	et, factory, office		28f. Location (Stree City or Town,	et and Number or Rui State)	al Route Number,
_	spital ours neral filled		29a. Certifier 1 Certifying Physician: To the be	est of my knowledge, death	occurred at the tim	ne, date and place	e and due to the cau	se(s) and manner as	ptatad
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basi and manner	s of examination and/or inv	estigation, in my op	pinion, death occ	urred at the time, date	e and place, and due	to the cause(s)
	To the within To the Comp	ĭ	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Month	. Day, Year)
i	0)		· U/noe		D	0065	385	April 2	5.2008
			30. Name and address of person who completed cause of		rint)			,	,
				dical Center istrar's Signature	Drive, R	ockville	, MD 2085	0	
	Stat Registra		APR 2 8 2008	istrar's Signature	ette s				
			- CALLERY CONTROL OF THE CALLERY CONTROL OF T	and her hallow	- Martin				

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 3 0 2008

Division or Vital Records, P.O. Box 68760.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician Melisha Ann Price 1557 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner TALbot Memorial Hospital EASTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 K F 218-70-3263 50 Maryland April 14, 1958 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD Caroline Preston Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21655 USA 23663 Grove Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2€ If Yes, Give Year or Dates: 2 No 1X Never Married 2 ☐ Married 1 ☐ Yes 🏋 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Faulkner William Bryan Price Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23663 Grove Road, Preston, MD Belinda Price sister in law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/08 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. : K. 12 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 54RS disease or condition resulting in death) Due to (or as a consequence of): SIABETES if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 44 PERTENSIO, Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RHOLESTERDLEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown TYPER CALCENIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an RONAL FAILURE 1 Yes as case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Yes 2 No 27. Manner of Death 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury

The law requires that the death certificate be executed use as the burial-tran Division or Vital Records, P.O. Box 68760 attending physician this certificate has page 2 Attending Physician: funeral To the most after death.

Within 24 hours after death.

To the Funeral Director: Aft

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Funeral

Director

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Pages 1 ment of H permit. Pages Department of Important: If it any injury or c

Physician

/Medical

Examiner

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Maryland

Baltimore,

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If Item 27 is marked of lier than "natural", or items 23a or 28a-f show or other traumatic evert, the Medical Examiner must be notified at

Physician/Medical Certification: To

Completed by Be

1 Vatural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

(Check only

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number D48064

505 Dutchmans Lane, Easton, MD

29d. Date signed (Month, Day, Year) April 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin Stitely, M.D. 31. Date filed (Month, Day, Year)

ar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** atherine 0955 A 2008 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number . Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 438-72-1426 63 June 3, Director 1944 Louisiana Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location Maryland Anne Arundel Annapolis 1 ¥ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? be filed within 72 hours after death with tatal Hygiene. 110 South Street must be 21401 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status the Medical Examiner 1 ☐ Yes 2,☐ No 1 Never Married 200 Married 1 ☐ Yes 2XXNo White Specify. þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Federal Investigator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Billeaud, Jr. Mental and Mental Williana Duffy permit. Pages 1 and 2 should be Department of Health and Menta. Important: If Item 27 Is marked any injury or other traumatic ewone. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel R. Piper, Sr./husband 110 South Street Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 4/25/2008 | Brentwood, Maryland 21. Signature of Fun eral sende Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 100 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Liver failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live birth 2 🗌 Fetal death in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) isigned by the att 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe 2 No 2 🗌 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the 3 Suicide Could not be

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, the Hospital or Attending

the Maryland

3altimore, Maryland 21215-0036

Medical within 2 To the

after hours Funeral

24

State Registrar

31. Date filed (Month, Day, Year) APR 2 5 2008

determined

4 Homicide

(check only one)

29b. Signature and title of certifier

29a. Certifier

32 Registrar's Signature

MD/PhD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number .

RES-000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2008

DHMH 17 Rev 1/2001

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director Funeral Baltimore, Maryland 21215-0036 þ Completed Be 2 Physician

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VISION OF VITAL DECORAS, P.O. DOX 00/00,	Attending Physician: The law requires that the death certificate be executed	er death.	rector: After this certificate has been signed by the attending physician and	by the funeral director, page 2 should be detached for use as the burial-transit	
>	- C	-	Φ	ō,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mida T. Ponton April 25, 2008 11:25A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Golden Living Nursing Home
5. Social Security Number 6. Sex 7. A Frederick
If Under 1 Year If Under 24 Hrs. Frederick Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 👿 F 83 Maryland May 24, 1924 216-14-5281 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Frederick MD Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 United States 1717 W. 7th Street Apt #2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Assembler Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mida E. Palmer Charles Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Ponton (spouse) 1717 W. 7th Street Apt #2 Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/29/2008 Frederick, Maryland Mt. Olivet Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike Frederick, Maryland 21702 Do not enter the mode of dying, such as pardiac or repiratory arrest, 7 a. Part1. Enter the disease, or compositions that shock, or he in failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) a Ttinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 ☐Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number no completed cause of death (Item 23a) (Type, Print) 30. Name and a ss of person 32. Registr State 2008 Registrar

DHMH 17 Rev 1/2001

				State of Maryland / Department of Health and M			1 500 00 00 50
				1 - State Registrar Certificate of Death		og. No UUÖ	155/3
	-	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Year	3. Time of Death 6:15 A M
	9	/Medic	al	Soren A. Peterson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	29 2008 4c. County of Death	1
	1	Examin	er	Atlantic General Hospital Berlin		Worceste	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign intry)
	Н	Director		389-12-8325 87 Yrs.	8. Date of Birth (Month, Day, 2/21/1	921	WI
		and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
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		r 28a	by Funeral Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	intry?
		th with	a D	4301 Island View Rd. 21863		USA	
		r dee	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spr. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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	9	within 72 hours after deeth with the Maryland ene. than "natural", or itema 23a or 28a-f ehow fra Madical Examinar must be molilled at	ted	15 Deceded 5 Streeting 150 Decedent's Head Occupation		16b. Kind of Business/l	ndustry
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120	and	ntal H od ott	Be	17. Father's Name (First, Middle, Last) Soren A. Peterson, Sr. 18. Mother's Name Olive U		walden Sumame)	
153	Maryland 21215-0036	2 should be and Mental is marked o	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur.		, City or Town, State, Z	ip Code)
04/24/2008		s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or itema 23a or 28a-f ehow other traumatic event, Ira Madical Examinar must be rediffed at		Janet Snowden / daughter 14290 Baker Mill Rd.,			
Ö	J.	es 1 a of Hei fitem r othe		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	Date	20c. Location - City or	Town, State
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DO	Baltimore,	permit. Pages Depertment of Important: If It any Injury or o				age Funeral	Home
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-	à,	Dhysisian		shock, or heart failure. List only one cause on tine. Immediate Cause (Final		1	Interval Between Onset and Death
a	7	Physician /Medical		disease or condition resulting in death) a		5-7-1-1	
110		Examiner		Sequentially list conditions b.			
2		D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Office or injury			
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2	O. E	the et hed fo	/sici	in the past 12 months? 1		WIG/AIT	Suy 1 Su.
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000	ooe	law requir as been si 2 should I	olete		24a. Was a	an 24b. Were au	topsy findings available completion of cause of
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25	ita'	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?	h Check only or	ne	
ري د ک	50	ling Physician: After this certific funeral director,	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho		ence 6 Other (Specow injury occurred	cify)
Soven		Attending Physician: It death. ector: After this certification. by the funeral director, I	E	1 Natural 5 Pending (Month, Day Year) 1 Accident investigation (Month, Day Year) 1 Accident investigation M 1 Yes 2 No	200. 00001100 11	on injury obcurred	
01,	Division	Attendi er death. ector: A by the fu	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office	28f. Location (S City or Tow	Street and Number or Ru	ural Route Number,
	ā	2 4 2 2	O	4 ☐ Homicide building, etc. (Specify)	Chy or You	,, State)	
		To the Hospital or within 24 hours effer To the Funerel Dirticompletely filled in I	edical	29a. Certifier (Check only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and my one) And manner stated.			
اد.		within 2 within 2 To the comple	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	h, Day, Year)
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	c-	/1,		30. Name and address of person was completed eause of death (yer) 23a) (Type, Print) A Hymre and address of person was completed eause of death (yer) 23a) (Type, Print) A Hymre and address of person was completed eause of death (yer) 23a) (Type, Print)	1- no	21811	
(ر آ	W+1		31. Date liled (Month, Day, Year) 32/Registrar's Signature	47 /14/	21011	
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/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a To the Hospital or Attending Physician: filled in by the f

Division or Vital Records, P.O. Box 68760,

Wayne Franklin Price, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death eninsula legional medical WICOMICO Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Davs Hours North Carolina Director 213-28-5318 76 Nov.15,1932 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 No Director DE. Sussex Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6777 Sharptown Road 19956 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Y No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married 1 □ Yes Ž No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plummer Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Price Della Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Price (Wife) 6777 Sharptown Road Laurel, Delaware 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cem. April29,2008 Laurel, De. 19956 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street 23a. Parl Enter the isease, or complications that caused the Path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause in each line. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emortusis ue to (or as a consequence of): SMall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ___npatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of . :uoi 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Certificati 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0059368 24/08 Salishury M.D 21804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll. ST E. V1520/1 100 ·UN 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 8:35 NATHAN R. PERRY JR. 10AiL /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 X M 2 □ F 012-24-1261 Director 76 MASSACHUSETTS JAN. 17, 1932 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or items 23a or 28a-f show miner must be notified at 1 X Yes 2 □ No Director OCEAN CITY MARYLAND WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 SEAWEED LANE 21842 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status "natural", or item Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1951-53 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 Widowed 4 Divorced WHITE Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) dother than veent, the Me Elementary/Secondary (0-12) College (1-4or 5+) 4 ELECTRICAL ENGINEER DEFENSE CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN PERRY SR. R. ELIZABETH 2 CULLEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURA M. PERRY/WIFE 609 SEAWEED LANE, OCEAN CITY, MARYLAND 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State EASTERN SHORE VETERANS
CEMETERY
22. Name and Address of Facility 5/1/08 4 Donation 5 Dother (Specify) HURLOCK, MARYLAND 21. Signatur of Funeral Service Licens HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Inter the disease, or complications that caused use death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) poxia **Physician** /Medical or as a consequence of Examiner Cord Compression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner g physician and requires that the death certificate be executed Non Small Cell Lung Cance Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 □ Yes 2 □ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: P 1 ☐ Yes 1 Inpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 166198

Registrar
DHMH 17 Rev 1/2001

State

100 E. CARROLL St. SAlisbury ma 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NGA1ZAMD

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2008

JUSTINIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Month **Physician** Phillips Elliott 26, 2008 4c. County of Death 2130 Norma /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Jalisburu Wicomica lisburyKehab+N ursing If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yfs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Director 3-10-1927 Maryland 218-20-7747 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2/☐ No Director MD Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21804 USA 106 May Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Shirt Factory permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Cooper Charles Brice Shockley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> Wayne White - C</u>ousin P.O. Box 551, Hebron, Maryland 21830 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-29-2008 Hebron, Maryland 4 Donation 5 Other (Specify) Hebron Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause the death. 23a. Part. Enter the disease, or complic shock, or heart failure. List only on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ear /Medical Due to (or as a consequence of): Examiner 12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical as signed by the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 DN6 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 r this certificate has ral director, page 2 autonsy perform 2 110 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours and To the Funeral Dir 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

orma

State Registrar 29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

rivic Ave,

29d. Date signed (Month, Day, Year)

08-03366 Roger Potter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

oger Potter		Sta 1- For State	ate of Maryland	/ Depa	rtment of H	ealth and		Hygiene) n	0.0	1507
D		Registrar 1. Decedent's Name (First, Middle	Loot	Cer	tificate of De	eatn	·	Re 2. Date of Deat	g. No. 💪 🔾	3. Time of D	J D /
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		4a. Facility Name of not institution	, give street and number)		46.0	city, Town, or I	Location of De		4c. County of De	ath	
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Director		219-60-1470	1 M 2 F	5	5 Yrs. N	ionths Days	Hours	Min. Feb. 5	1953	Country) Ma	ryland
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Mar. 188	Director	317 Chop	1		10	f. Zip Code		10		•	
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at be sath w	uneral		Armed Forces?					erto Rican, etc.)	White, etc		nack,
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5-0036 led within 7 Hygiene. other than the Medica	Ĕ	9			yard	Ca	reta	Ker ame (First, Middle, N	Privat	e Resid	lence
21215-0036 Id be filed within 7 dental Hygiene. narked other than event, the Medical		17. Father's Name (First, Middle,		٠. مــــــــــــــــــــــــــــــــــــ							
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y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once			Nilson		317 Ch	notan	VK AV	enue Fa	StON. M	avu la Na	21601
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more, Pages 1 a cent of He int: If ite			3 Removal from Sta	ate R.C	has de An	MA Pa	VV S	5/10/08	Easton	. Marc	iland
Baltir permit. F Departme Importai	1	4 Donation 5 Other Sp 21. Signature of Funeral Service	icensee /	hic	22. Name	and Address	of Facility	1 1/0/100 6	2.4.		
E.E. P. P. E.E.		21. Signature of Funeral Service January 23a. Fort I. Enter the disease, or	2. Henry	?	Hen	Wasi	nera hi wati	w St. Ca	mbridge	, MD	21613
Physician		23a. Pert I. Enter the disease, or failure. List only one cause	complications that cause	he death.	Do not enter the m	ode of dying,	such as cardi	ac or respiratory arre	est, shock, or hear	Approxim Between	ate Interval Onset and
/Medical xaminer		Immediate Cause (Final disease	a. Narcotic (morphi	ne) and alo	cohol in	toxicati	on.			eath
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be extended that the death. Functal Director: After this certificate has been signed by the attending physician tely filled in by the funeral director, page 2 should be detached for use as the burial	Med	IF FEMALE:	#23a, 27, 28			5/15/08	11		23d. Date of deli	verv	-
Ox 6876C ath certificate attending phys	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal d	eath 3	Ectopic pre	egnancy	Month	Day	Year
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Division of the price of the pr	Certification:	4 Homicide deter		ound a	it home			or Town, S 317 Chop	tank Ave. Ea	ston, MD	
Divisior To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the			ysician: To the best of m								
To the Howithin 24 h To the Fu	Medical		niner: On the basis of examiner stated.	mination a	nd/or investigation, 			red at the time, date			13
	Σ	29b. Signature and title of certifier	1			29c. Licens			29d. Date signed	(Month, Day, Ye	ar)
		Van MU	ind IMID.			O.C.I	ıvı.⊏.		May 3, 2008		
		30. Name and address of person Donna M. Vincenti, MI	Accietant Medic			enn Street	Raltimore	, MD 21201			
	ate		Assistant Medic	r's Signatu		M Oueel,	, 201111016	, NID Z 1201			
St Regist	аце гаг	MAY 0 8	2008	ر رو	5 AD34						

		1	For AMEND#10eperINF5- State AMEND#10eperINF5- RegistraMEND#9perINF5	State of Maryla 3-08, BW, McCo	and / Depa	artment of rtificate o	Health a f Death	ind Ment	al Hygie Req	ne 200	8	15678
			1. Decedent's Name (First, Middle, Last)	-2-00,H-M,F-CC	,				ate of Death			Time of Death
	Physicia /Medic	_	MARY	C. RU	INFOLA				onth PRIL	Day Ye 26, 2008		0:35 A ^M
	Examin	106 are	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	, or Location of	f Death		4c. County of D	Death	
200 L		ĝr.	BRIGHTEN GARDENS			CHE If Under 1 Year	VY CHAS		ate of Birth	MONTGOM		(State or Foreign
	Funeral		5. Social Security Number 6. Sex	M 2FXF	rs. last birthday) Yrs.	Months Day		Min. (N	fonth, Day, Y	ear)	Country	NEW YORK
	Director	1	058-12-3595 Usual Residence of Decedent	8	0			FIA	AY 31,	1921		
	yland now at		10a. State 10b. County	10c.	City, Town or Lo	ocation						Inside City Limits
	e Mar la-f sl tified	ctor	MD. MONTGOME	RY		CHEVY						1 X Yes 2 □ No —————
	ith th	Director	10e. Street and Number 4620 N. Park A	ve #1203-	-W	10f. Zip Code			10g	j. Citizen of Wha	t Country?	
	he flied within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	eral	-4620 N. PARKLA	WN AVE. 12. Was Decedent Ever in	nIIS 13	Was Decedent of	20815	nin? (Specify Y	es or No-	U.S.		ndian,
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2	ursal al", ol Exam	by	3 ☐ Widowed 4 🎞 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 汉 N	No Specify:			Specify:	WHIT	CE
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7	e filed wal Hygie other t		17. Father's Name (First, Middle, Last)		CON	GRESSION			it, Middle, Ma	aiden Surname)	CEPRES	SENTATIVES
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	Discontinuo.	9.	shock, or heart failure. List only of	ne cause on each line.							Or	nset and Death YEARS
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<u>.</u>	at the de I by the a stached	Physician/Me	9 ☐ Unknown Part II. Other significant conditions co		t reculting in the	underlying cause	aivon in Part I		23e Did tobs	acco use contribu	ute to the c	eause of death?
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Division or	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S)	At home, farm, s pecify)	treet, factory, off	fice		Location (Stre City or Town,	eet and Number State)	or Rural R	oute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifical completely filled in by the funeral director.		29a. Certifier 1 X Certifying Phy	rsician: To the best of my	v knowledge, dea	ath occurred at the	ne time, date ar	nd place, and	due to the ca	use(s) and manr	ner as state	
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	To th Mithin To th	Me	29b. Signature and title of certifier	10	1	29c. Lic	cense number	_	29	d. Date signed (Month, Da	y, Year)
	15		1 Levina.	Nealon	, M.D.		D002312	27		APRIL	28, 2	2008
	U		30. Name and address of person who c			, Print)						
			KEVIN G. NEALON	M.D. 5		CONSIN A	VE. SU	ITE 140	00, CHE	EVY CHAS	E, MI	20815
	Sta	ate	31. Date filed (Month, Day, Year)	209	Januard Control of the Control of th	mente						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Regist AMEND#5, perFH, 4/30/08, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 23, 2008 М Gertrude Α. April 11:45a Ripley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery ial Security Number 4-18-8221 4-18-8224 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 1 1 F Director 94 15, 1913 Maine Nov. Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits show at r 28a-f sh 1 ☐ Yes 2 X No Maryland Prince George's Beltsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural'', or items 23a or 3 dicai Ex-miner must be n 3203 Fairland Road 20705 IISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced ear or Dates White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arlo Beal Unknown Small 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Clahane/Niece 2416 Falling Creek Road, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 30 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or Hill Crest Memorial, 2008 Washington Township, NJ GIouce Steename and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 800 500 University Blvd, W, Silver Spring, MD 20901 asses Approximate Interval Between Onset and Death 23a. Part1. Writer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Severe Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underly of Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) executed Acidosis sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician death certificate be Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) detached the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 should be Renal Failure 2 No 3 Probably 4 Munknown 1 ☐ Yes Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 **V** No 1∐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 M Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 April 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar



			artment of Health and Mental	Hygiene				
			rtificate of Death	Reg. No. 9 1 5 6 9 1				
Physi		1. Decedent's Name (First, Middle, Last)	2. Date of Month Apri	of Death 2 0 0 3. Time of Death 1 2 4, 2008 4:03P M				
/Med Exam	dical niner		4b. City, Town, or Location of Death	4c. County of Death				
		Shady Grove Adventist Hospital	Rockville	Montgomery				
Funera Directo		5. Social Security Number 315-07-0536 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Dec.	of Birth th, Day, Year) 9. Birthplace (State or Foreign Country) 12,1915 West Virginia				
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits				
Maryla f show	à	Total Ottalo	Berlin	1 X Yes 2 No				
the last	rect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
h with 3a or	٥	79 Teal Circle	21811	USA				
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21213-0035 td 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry				
d with giene.	Ē	Elementary/Secondary (0-12) College (1-4or 5+) Foric	egn Service Officer					
be file tal Hy I othe	<u>a</u>	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	,				
yla lould t i Ment larkec	Ę	Robert Lucien Reinhart	Katherine C	Clyde Schober				
Mal d 2 sh th and 7 is m traum		, , , , , , , , , , , , , , , , , , , ,	ing Address (Street and Number or Rural Route N Lorain Ave., Silver					
Te, I		20a Method of Disposition 20b. Place of Disposition	osition (Name of Date	20c. Location - City or Town, State				
TO Pages ent of it: If it		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ② Conation 5 □ Other (Specify) Howard	University 4/26/08	Washington, DC				
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev	once.	21. Sign thre of Juneral Service License	22. Name and Address of Facility Austin	Royster Funeral Home .W., Washington, DC2001				
	1	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.						
bhysicia and sician and purial-transit	al er	Respiratory Insufficiency Due to (or as a consequence of): Sequentially list conditions, if any, leading to him solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):						
8760, cate be exemple; bhysician a the burial-i	1 7	d						
vision or Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reath. reach: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ion/Mo		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year				
that I ed by detac	ļ		underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?				
COTGS, P w requires that s been signed t should be deta	1	Chronic Obstructive Pulmonary	Disease	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
VITAI HECONDS, sician: The law requires the certificate has been signerector, page 2 should be d	potologic	Hypernatremia	24a.	. Was an autopsy prior to completion of cause of death? Yes 2 № No 2 № No				
VITAI HEC sician: The law certificate has l irector, page 2 s	5		1 □ 26. Place of Death (Check					
r VI nysici is cert direct	OF OF	examiner?	ent 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)				
DIVISION OF I or Attending Physicater death. Director: After this of in by the funeral direction of the funeral direction.		On Date of brings	of 28c. Injury at 28d. Des	scribe how injury occurred				
Division al or Attend s after death. al Director:	911	27. Magner of Death 1 A Natural 2 Accident 3 Suicide 4 Homicide 2 Rending investigation 3 Suicide 4 Homicide 2 Rending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Place of injury - At home, farm, s		ation (Street and Number or Rural Route Number, or Town, State)				
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, dear (Check only one) 29a. Certifier 2 Certifying Physician: To the best of my knowledge, dear one one one one of the best of my knowledge, dear one of the best of my kno	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)				
To the within To the Somple	2		29c. License number	29d. Date signed (Month, Day, Year)				
7_		machan tuboy no	D0062562	APRIL 24 2008				
		30. Name and address of person who completed cause of death (Item 23a) (Type MADNAVI HUBBIT 9901 MEDICAL	Print) CENTER DRIVE ROCKY	TILLE MP 20850				
	State	100 00 0000 100	esti)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 20, 2008 April 8:35 Rubenstein /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Hebrew Home of Greater Washington Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours 9/129 Pro 161 127-44-1472 1 □ M 2 XF 96 NY Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1XYes 2 □ No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 6121 Montrose Road Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the <u>Medical Examiner must</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Singer Louis Levin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8567 Blackfoot Court Lorton VA 22079 Mira E. Leckner - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David Memorial Gardens 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/22/2008 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) After this certificate has been signed by the attending physician Physician/Medical IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Z No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1☐ Yes 12☐ No 2 No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No s after death. investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

08-03396 Elana Beth Reitbe	rge		ase Tyj St	oe or Pr ate of M	i nt in Bl Iaryland	ack Inde	ment o	f Healt	n and r	All Copie Mental H	es Are ygien	e Legib e	le.	a a	0 1500
	R	For State egistrar	- (F) 1 1 A A A	In Lent)		Certif	icate o	of Death	7		2. Date	Reg. N		3.	Time of Death
Physician Medical Examine		Decedent's Name Elana	e (First, Midd L	Beth	R	EITBERG	GER					th Da 3, 2008			2354 hrs
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v any		Ioa. State	10b. County			10c. City, To			~					10	Od. Inside City Limits Yes 2 X No
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he Mar or 28s	Director	10 Year		ourt					20902				U.SA		
ı with the mas 23a	_ L	11. Marital Status	· 2 🗀		Wes Deceder Armed Forces		13. V	Vas Decede Yes, speci	ent of Hispa fy Cuban, N	anic Origin? (S Mexican, Puert	Specify Y o Rican,	es or No- etc.)	14. Race - White,		n Indian, Black,
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21215-0036 sold be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) I saac Reitberger 18. Mother's Mi										Middle, Mai Eis	enfeld	-0.7%43,2	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	108	19a. Informant's N	Print) fathe	Rural R	. Shiri	er, City or Towr	2030								
e, MD I and 2 sho Health and item 27 is	1	110 1.15				20b. Pla	ace of Disp ematory or	position (Na	me of ceme	etery,	Date		Oc. Location -		
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of F	1	12011	~	>	1:	254 Ca	arrol	1 St	NW.	Washi	ngton,	DC 2	eral Home 20012
Physician	\dashv	23a. Part I. Enter failure. List of	the disease,				Do not ente	er the mode	of dying, s	such as cardiad	or resp	iratory arres	t, shock, or hea	art	Between Onset and
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Box 68760, e death certificate be ex the attending physician red for use as the burial	sician/Medical	IF FEMALE: 23b. Was decede	nt pregnant i	2		come of pregn		Fetal deal		Ectopic pre	gnancy		23d. Date of Month		ay Year
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Divisior Hospital or Attend 24 hours after death. Funeral Director:	Certification:	3 Suicide 4 Homicid	le C	could not be etermined	(Specify)	found	at ho	me _			10		n Ct. Si		Spring, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fitneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	20a Certifier		Examiner: 0	n the basis of	examination a	ge, death o	occurred at stigation, in	the time, da my opinior	ate and place, n, death occurr	and due	to the cause time, date	e(s) and mann- and place, and	1 000 10 11	10 00000(17
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		30. Name and a	ddress of pe . Vincenti		npleted cause ssistant_M	of death (Item edical Exar	n 23a) m iner	111 Per	n Street	t, Baltimore	e, MD 2	21201			
	tate	31. Date filed (A			100	istrar's Signa			9						
Regis	tra														

Certificate of Death

Reg. No.

April 23, Day 2008

3. Time of Death

9. Birthplace (State or Foreign

10d Inside City Limits

pproximate Interval Between Onset and Death

Vear

9 days

years

Day

29d. Date signed (Month, Day, Year)

April 23, 2008

1 XIYes 2 □ No

5:00 A M

2. Date of Death

31. Date filed (Month, Day, Year) APR 3 0 2008

Griffin,

29b. Signature and title of certifier

29a. Certifier (Check only

Gail T.

1. Decedent's Name (First, Middle, Last)

Anita Huffman Rodgers

Physician

/Medical

M.D. 1502 S. Main Street Suite 202 Mt. Airy, MD 21771 32. Registrar's Signature The Shipping of the State of th

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D55104

State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Day Year **Physician** Rutman tha 2008 /Medical 4a. Facility Name (It not institution, give street and number)
Pleasant View Nursing Home
4101 Old National Pike 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ount arrol PIKE Date of Birth (Month, Day, Year) Dec. 1, 1955 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months 1□ M 2√F Hours Japan Dec. 266-15-9619 53 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 28a-f shov notified at 1 ☐ Yes 2 ☑ No Director Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ber 4101 Old National Pike 21771 United States "natural", or items 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

Interest of the and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home and Mental Hygie Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Rutman Thelma Brown ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Brackins / Sister 7600 Roanoke Ave., Newport News, VA 23605 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any Injury or once, ō 4/28/2008 Stauffer Crematory Frederick, Maryland 4 Donation 5 Dother (Specify) 21. Sign up of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION FRW Hours disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant et time of death 5 ☐ Other (specify) signed by the a 2-1 No 9□Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SCHIZO PHRENIA 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No DISORDER BIPOLAR 2 No 1 TYes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: P 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D. 30469

State Registrar 31. Date filed (Month, Day, Year)

8850, COLUMBIA

32. Registrar's Signature

APR 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 8 50, CoLUMBIA 160 (ARKWAY # 30 8,

COLUMBIA.

MD . 21045-2377

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8 Edward Warren Russell 200 8 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-22-1926 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Maryland Director 220-16-8541 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Director MD Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 3 21853 USA 30450 Harvey Russell Road Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Truck Body Builder none other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othward any injury or other traumatic event one. Harvey Russell Ruth Green ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30450 Harvey Russell Road, Princess Anne, MD 21853 Mildred L. Russell/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland Salisbury Crematory | 04/29/2008 | Signature of Funeral Pervice Licenses 22. Name and Address of Facility Hinman Funeral Home MD 21853 11673 Somerset Ave., Princess Anne, M00295 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -atheros den tic cardiovascular disease) Physician /Medical Due to (or as a consequence of): Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Be Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Carroll Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 G.

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	State of Maryland /	Department of H	ealth and Mer	ntal Hygiana

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	death	Funeral Director	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Was Decedent of H f Yes, specify Cuba		pecify Yes or N		14. Race - Al Black, W	merican Ind	lian,
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/land	Ald be Alenta rked ric ev	To B	Michael	Phillip	Rineholt				Carildi	a Workm	an			
Mary	and Nand Is ma		19a. Informant's Na	ame/Relationship	(Type. Print)	191	b. Mailin	ng Address (Street	and Number or R	ural Route Num	ber, City o	r Town, State	e, Zip Code)
e,	and and n 27			Rineholt	:/Wife	21	12 I	Line Brid	ge Road,	Whitef	ord,	MD :	21160	
ore	ges 1 t of H if iter or oth		20a. Method of Disp 1 ☐ Burial 2		☐Removal from State	20b. Place o	of Dispo ery, cren	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City	or Town, S	tate
банттог	:. Pag tmen tant: ijury		4 □ Donation	5 ☐ Other (Spec	cify)	Evans		gle Crema		7/08		a, PA		
a D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	ineral Service Lic	ensee /	2/		Name and Addre	•	me Inc		00 Maii		eet
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UIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 Homicide	determine	building, etc	c. (Specify)	,	oot, tablety, emec			own, State		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
-	spital ours neral		29a. Certifier	1 Certifying	Physician: To the best	of my knowledg	ge, deat	h occurred at the ti	me, date and place	e, and due to the	ne cause(s) and manne	r as stated.	
	e Ho	Medical	(Check only one)	2 ☐ Medicai Ex	taminer: Of the basis of	examination a	and/or in	vestigation, in my	opinion, death occ	urred at the tim	ie, date an	d place, and	due to the	cause(s)
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month **Physician** <u> William C. Schmeisser Jr.</u> /Medical 2008 April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11606 River Road Potomac
er 1 Year | If Under 24 Hrs.
s Days Hours Min. Montgomery 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 1**7** M 2 □ F Director 131-22-0391 12/16/1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland|Montgomery Director Potomac 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Medical Examinar minimater. 11606 River Road 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tyes 2 No WWII If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ò Specify: 3√E Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney U.S. State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Schmeisser Isabell Jelke Wooldridge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Schmeisser, Son 5 Belmont Street, Milford, CT. 06460 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln Crematory 4/28/2008 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Primary Lymphoma of Bone Due to (or as a consequence of): 6 Months /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No ate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1□ Yes 2☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 2₩ No Hospital: မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔁 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director.

Medical

29b. Signature and title of certific

4 Homicide

(Check only one)

29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

🛮 🔼 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D23308

4/21/2008

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

and manner stated

Victor M. Priego, M.D.

6420 Rockledge Dr. #4100, Bethesda, MD 20817

State Registrar 31. Date filed (Month, Day, Year) APR 29 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2008 SULLIVAN **Physician** ABBILL 16 PM DISE 10 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 21, 1932 7. Age (In vrs. last birthday) 1 □ M 2X F Yrs. New York 074-26-7470 76 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location South Yes 2 □ No Director Surfside Beach Carolina Horry 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 655 5th Avenue North 29575 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20℃ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Social Worker Non-Profit Organization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Zanzucchi. Jennie Mollineli 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Eugene J. Sullivan/Husband 655 5th Ave. N. Surfside Beach, SC 29575 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State April 30 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2നവ Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTOPLE - DAYS disease or condition resulting in death) ge to (or as a consequence of): I HREMBOLYTOPENIA APIN - INDUCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine TENOSIS TORTIC Due to (or as a consequence of): Physician/Medical þ Completed Be ည

that the death certificate be executed burial-trar Box 68760. ding physiciar as the atter signed by the att Division of Vital Records, P.O. has filled in by the funeral Hospital or Attending After

Director: after

To the Hospital within 24 hours a To the Funeral D

Funeral

Director

iten 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after

and Mental

Pages 1

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	ge. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown
		ia. Was an autopsy performed? yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Chec	k only one)
examiner? 1 Yes 2 No	Hospital: Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Sec. Injury at Work? M 1 Yes 2 No	escribe how injury occurred
3 Suicide 6 Could not be determined	Zoe. Flace of injury - At nome, family, street, factory, office Zoi. Lo	cation (Street and Number or Rural Route Number, y or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in small 29a. Certifier

KES-000

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number

IAO, M.D.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AO, M.D

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month, Day, Year)

APR 29



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State of Man		artment of H <i>rtificate of L</i>			ene 20	08	15689
Physi	ician	Decedent's Name (First, Middle, Last)				Date of Death Month	Day	Year	. Time of Death
/Med	dical	Ruth L. 4a. Facility Name (If not institution, give street and number)	Sawel		Location of Death	April	25, 20 4c. County o		3:55 P ^M
LXaii	illici	221 Booth Street, #220B			ersburg		Mont	gomery	7
Funera Directo		132-16-2111 1□ M 2ĪXF	In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Oct. 27,	^{'ear)} 1920	9. Birthplace Country) New Y	ork
aryland show	Ļ	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Loc	cation					Inside City Limits
the Ma 28a-f	Director	Maryland Montgomery 10e. Street and Number	Gaithersh	ourg 10f. Zip Code	. -	100	ı. Citizen of WI		1 □ Yes 2 □ No
3a or	Β	221 Booth Street, #220B			878	100	USA	nat Country?	
ING ZIZIS-UUSD be filled within 72 hours after death with the Maryland ntal Hygiene. cd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Event Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	lf.	Vas Decedent of Hi f Yes, specity Cuba	spanic Origin? (Spon, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race	- American I , White, etc.	ndian,
LID-UUSO thin 72 hours af e. an "natural", or Medical Exam	ed by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	16a. Deced	I □ Yes 2 No Ient's Usual Occupa	Specify:	16	Specify: 6b. Kind of Bus		Thite
d ZIZIS filed within 72 Hygiene. ther than "na ent, the Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done o OO NOT use retired Lunteer	luring most of work)	ing			s/Red Cro
al Hygi	Be Co	17. Father's Name (First, Middle, Last)	1 101	Luncon	18. Mother's Name	(First, Middle, Ma			Sylica of o
aryian should be ind Mental marked o	P	William Lesnick			Rebeco		Ginst		
2 8 8		19a. Informant's Name/Relationship (Type. Print)	1	g Address (Street a					
re, rv s 1 and r Health tem 27 other tr		Beth Zimet, daughter 20a. Method of Disposition	20b. Place of Dispos	Scarlet sition (Name of	1 [oc. Location - C		
Pages nent of int: If I		1 X Burial ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Garden of Memorial	Remembra Park	ince 4/29	/2008 C1	arksbu	rg. Ma	rvland
Daltimore, n permit. Pages 1 and Department of Health Important: If Item 27 any injury or other t	ouce	21. Sign ure of uneral space (closee)	22.	. Name and Addres	s of Facility H i n	es-Rinald	li Fune	ral Ho	
Physiciai		23a. Part1. Enter the discusse, or complications that caused the shock, or heart fa ura List only one cause on each line.	e death. Do not ente					Ap Inte	proximate erval Between set and Death
/Medica	ıl	disease or condition resulting in death) a. Alzheim Due to (or as a condition)							
Examine	e e	Sequentially list conditions, b. Due to (or as a c	consequence of):						
uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or high) that initiated events	onsequence or).						
icate be executed physician and the burial-transit		resulting in death) Last C. Due to (or as a c	onsequence of):						
cate be ex ohysician a	dical	d							<u>-</u> .
death certified attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf. 1 □ Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day	/ Year
requires that the een signed by th	b	Part II. Other significant conditions contributing to death but r	not resulting in the un	nderlying cause give	en in Part I.	23e. Did toba			ause of death?
law requires as been sign 2 should be	eted					24a. Was an			findings available
The law icate has b	Completed					autopsy performe	pr	ior to comple eath? Yes 2	etion of cause of
Or VICAL Physician: 1 rithis certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	t 3 DOA Othe	· · ·	n (Check only one)	C []Ott	(01-1)	
ng ng	-	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Y) 2 ☐ Accident investigation	28b. Time of	28c. Injury Work	4 🗆 140/3/1/9 / 10	me 5 🕅 Residen 28d. Describe how			
lor Attending after death. Director: After lin by the fune	Certification:	2□ Suiside 6□ Could not be	- At home, farm, stre (Specify)			28f. Location (Stre City or Town,	et and Number State)	r or Rural Ro	oute Number,
To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) 1	kamination and/or inv	occurred at the time restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and man e and place, a	ner as stated	d. e cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	-	29c. License	number	290	I. Date signed	(Month, Day	, Year)
.~		· Mees	97/	7 D	26259	Ar	ril 28	, 2008	3
10		30. Name and address of person who completed cause of deat		Print)				·	
	itate	Ava A. Kaufman, M.D., M.P. 31. Date filed (Month, Day, Year) 32	H., 8218 N	Wisconsin	Avenue,	Bethesda	, Mary	Land 2	0814
Regis		APR 2 9 2008 Seem	s Signature	SAE)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 April 24, 3:20 PM Sommer Sall_v 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, June 29 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🖔 F Months New York 92 101-05-2610 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 01ney Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20832 3354 Megans Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Mermelstein Joseph Mermelstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olney, MD 20832 3354 Megans Way Fred S. Sommer-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 N Removal from State 4 □ Donation 5 □ Other (Specify) 04/28/2008 Farmingdale, L.I., N.Y. Ararat Cemetery 21. Signature of Funeral Service Licenses 22 Name and Address of Faculty DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DISCASE Oro NAVY Syears disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the burial ned by the a cate has been signed page 2 should be det completely filled in by the funeral director, After this 24 hours after death.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be (2

Certification: To

Medical

30. Name

29b. Signature At title of certifier

31. Date filed (Month, Day, Year) APR 2 8

2

MD

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, It. Modical Exp. in a final by notified at once.

Physician

/Medical

Examiner

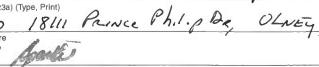
Baltimore, Maryland 21215-0036

3b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	23d. Date of delivery Month Day Y				
art II Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?	
Cerchro vascula.	Accident			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?	
5. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ☑ No ath (Check only one)	1 □ Yes 2 DVNo	
examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 npatient 2	ER/Outpatient 3 🗆 🛭	Other:	Home 5 ☐ Residence	6 ☐ Other (Specify)	_
7. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, street, factory)	ry, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)	
	vsician: To the best of my kno Iner: On the basis of examina) and manner as stated. d place, and due to the cause(s)	

29c. License number D18726 29d. Date signed (Month, Day, Year)

State Registrar CHOENGOLD Registrar's Sig*n*ature

od address of person who completed cause of death (Item 23a) (Type, Print)



within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Registrar	State of	Maryland / De	epartment of H			ene 008	15691
Physician	Decedent's Name (First, Middle, John Franklin St					2. Date of Death Month April 25	Day Year	3. Time of Death 9:55 p
/Medical Examiner	4a. Facility Name (If not institution,	give street and numb	oer)	4b. City, Town, or	Location of Death		4c. County of De	
	Brooke Grove Nurs				Spring	D. D. L. of Birth	1	pomery
Funeral Director	5. Social Security Number 170–26–0821	5. Sex 7. 12 M 2 F	Age (In yrs. last birtho	Months Davs	Hours Min.	8. Date of Birth (Month, Day, Feb. 9.	Year) (irthplace (State or Foreign Country) nsylvania
47	Usual Residence of Decedent							
yian how	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
e Ma	Maryland	Montgomer	y Sil	ver Spring				1 Yes 201 No
with the Mar		ive		10f. Zip Code 209 0	04	10	ng. Citizen of What (USA	Country?
TOTE, INSTITUTE A LATE 13-0030 ages 1 and 2 should be filed within 72 hours after death with the Maryland att of Health and Mental Hygiene. If item 27 is marked other than "neture!", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at		Armed Ford	es?	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Race - An Black, WI	nerican Indian, nite, etc. White
turet; or	3 Widowed 4 Divorced 15. Decedent's	Year or Dat	es: Korea	ecedent's Usual Occup	ation		16b. Kind of Busines	ss/industry
A I A I D-U	(Specify only highest Elementary/Secondary (0-12)		li.	Rive kind of work done : fe. DO NOT use retired Seneral Contra	1)	rking	Own Busi	iness
iled v Hygier ther th				Circlet Correct		me (First, Middle, N		
Mental H		-0.7				ia Sanner	,	
shound M	19a. Informant's Name/Relationshi	p (Type, Print)	19b. N	lailing Address (Street			City or Town, State	, Zip Code)
and 2 and 2 alth a 1.27 lt	Dan A. Snyder/Son		1772	0 Country Hi	lls Road, A	Ashton, MD 2	20861	
Dallimore, Initial Pages 1 and 2 Depermit. Pages 1 and 2 Deperment of Health a Important: If item 27 is eny injury or other tra once.	20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Spe		ate cemetery,	isposition (Name of crematory or other place		ii 30,	20c. Location - City	
Dallimor Permit. Pages Department of mportant: If it my injury or o	21. Signature of Funeral Service Li		ROCKWOOO	22. Name and Addre	ss of Facility	008	Ch.	Permsylvania
Depermine on in in in in in in in in in in in in in	day of	Carolin		Francis J. (500 Univers	Collins Fur ity Blvd, V	neral Home : V. Silver S	Inc. oring, MD 20	901
Physician -	23a. Part1. En er the disease, or c shock, or leart failure. List of Immediate Cause (Final disease or condition	nly one cause on ea	hed the death. Do not ch line.		ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death 2 weeks
/Medical Examiner	resulting in death)	a	r as a consequence of)					
pe sit	Sequentially list conditions, if any, leauning to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consequence of)					
ate be executed physician and the burial-transit	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of)					
		d						-
nat the death certificate be executed by the attending physician and letached for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live bir 4 ☐ Pregna	ome of pregnancy th 2 Fetal death nt at time of death	3 Ectopic pregnancy 5 Other (specify)	/		23d. Date of o	delivery Day Year
at the at the stacker	9 Unknown	9∐ Unknov				OO. Didas		to the access of death?
wrequires that the de been signed by the should be detached	Part II. Other significant condition Dysphagia, Hyperto	-	ith but not resulting in the	ne underlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
The law requires the has been signed age 2 should be considered by						24a. Was a autops perform	y prior t ned? death	
VITAL I					an Division of Div	1 Yes 2		es 2 No
Or VICA Physician: r this certific ral director,	examiner?	Hospital: 1 🗆 In	patient 2 ER/Outp	atient 3 DOA Oth	.00	ath Check only on	ence 6 Other (S	necify)
ding Phy h. After this funeral d	1	28a. Date of (Month		ne of 28c. Injury			ow injury occurred	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place o	of Injury - At home, farm g, etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in		Physician: To the to xaminer: On the base and manner	pest of my knowledge, or stated.	death occurred at the to or investigation, in my o	me, date and place opinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
To the complete compl	29b. Signature and titlerof certifier	amsin	M	29c. Licens D53	se number 3367		9d. Date signed (Mo April 26, 200	
201	30. Name and address of person w Shyamsundan Rajan		of death (Item 23a) (T		ver Spring	, MD 20902		
State Registra	31. Date filed (Month, Day, Year)	J. Re	gistrar's Signature	hacker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Sue Seldeen <u>April</u> 2008 12:40 A. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 9508 Midwood Road Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) March 28, 1916 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Months 1 □ M 🛠 🗆 F 92 Russia 220-48-8720 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9508 Midwood Road 20910 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Years Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elman Nathan Wiener Ada 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 MARTIN Seldeen - Husband 9508 Midwood Road, Silver Spring, Maryland Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 □ Cremation 3 X Removal from State King David Mem. Gdns 4/22/2008 Falls Church, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Edward Sagel Funeral Direction, Inc. Donald (20852 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 Hours Pneumonia Due to (or as a consequence of): 6 Months Metastatic Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Parkinson's Disease Completed Be ပ Certification:

Examiner Division or Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Nursell director, page 2 should be detached for use as the burial-transit

Physician

Examiner

Funeral

Director

r 28a-f show notified at

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Physician

/Medical

Baltimore, Maryland 21215-0036

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Director

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Completed

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Examiner

/Medical

				24a. Was an autopsy performed? 1□ Yes ※ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No		
25. Was case referred to medical			26. Place of De	ath (Check only one)			
examiner? 1 ☐ Yes 🌋 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3□ [OOA Other: 4 Nursing H	x sing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred		
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	Location (Street and Number or Rural Route Number, City or Town, State)		
	nysician: To the best of my kn miner: O the basis of examin and manner stated.				and manner as stated. It place, and due to the cause(s)		
29b. Signature and title of certifier	///-	2	9c. License number	29d. Dat	te signed (Month, Day, Year)		
Valla	Elluin		D13818	Apr	i1 21, 2008		

State Registrar

Medical (

Gary Fisher 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year)

APR 28 2008

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryland		rtment of F			ene g. No. 2 () () ()	3 15693	
	Physici	an	1. Decedent's Name (First, Middle, Last) Charles D. Shecke	ells, Jr.				2. Date of Death Month April 2	Day Year	3. Time of Death 9:50 P M	
	/Medio	- 5	4a. Facility Name (If not institution, give s Anne Arundel Medic	treet and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	ath	
5	Funeral Director		Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry) laryland	
1.2	0	ior	Usual Residence of Decedent 10a. State MD 10b. County Anne Aru		, Town or Lo	cation		- OCC - IS		10d. Inside City Limits 1 □ Yes 2 X No	
	with the lagarante and the lagarante	I Director	10e. Street and Number 295 Ternwing Driv	ve		10f. Zip Code 21012	2	10	10g. Citizen of What Country? USA		
9600	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Heath and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ¼Yes 2 □ No If Yes, Give Year or Dates: Korea War	 Was Decedent of H f Yes, specify Cub 		io Rican, etc.)	14. Race - Am Black, Whi Specify:	white		
Maryland 21215-0036	I within 72 jene. r than "nat the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)	kind of work done OO NOT use retire	during most of words Toreman	rking	Ellicott Company	•		
/land 2	uld be filed Mental Hyg Irked other Itic event,	To Be C	17. Father's Name (First, Middle, Last) Charles D. Sheck	ells, Sr.				ne (First, Middle, M beth Serra			
, Mary	and 2 sho salth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type Catherine A. Sheck	ells/ wife	295	Ternwing	Drive A	Arnold, M	City or Town, State, aryland 21	012	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 Burial 2 XCremation 3 R 4 Donation 5 Other (Specify)	emoval from State 1		sition (Name of natory or other pla cematory	Apr 20	il 25,	eoc. Location - City o Baltimore,	·	
Balt	permit. Departi Importi any inj		21. Signature of Fraeral Service License	21						uneral Home MD 21146	
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	0.	m cn , ence of):	7	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death	
,0928	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
P.O. Box 6	The law requires that the death certificate has been signed by the attending progge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic pregnand] Other <i>(sp</i> ec <i>ity)</i> _	су		23d. Date of d Month	elivery Day Year	
rds, P	quires that in signed build be deta	ğ	Part II. Other significant conditions cor	ntributing to death but not resu	ilting in the u	nderlying cause gi	ven in Part I.	23e. Did tob		to the cause of death? Probably. 4 Inknown	
Division or Vital Records,	r; The law re icate has bee r; page 2 sho	Completed						24a. Was ar autops perform 1∐ Yes 2	v prior to	autopsy findings available o completion of cause of es 2 \(\text{No} \)	
Z.	Physician; r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ot	hor:	ath <i>(Check only</i> one Home 5 ☐ Reside	e) •nce 6 ⊡Other <i>(Sp</i>	necify)	
0 U	ing Ph After th uneral	on: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo			w injury occurred		
Divisio	To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str			28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,	
	Fo the Hospital within 24 hours a fo the Funeral completely filled	Medical C	29a. Certifler (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, deat tion and/or in	h occurred at the t vestigation, in my	time, date and plac opinion, death occ	e, and due to the ca urred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	To the Within To the	Me	29b. Signature and title of certifier	ull m	2	29c. Licen		1	9d. Date signed (Mod $4/25/6$		
1	5CH		30. Name and address of person who co		23a) (Type, M /	Print) Acc	1 medie	al Pari	Knay, A	napols, m	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Rafistrar's Signa	ture L				. /		

State

DHMH 17 Rev 1/2001

Registrar

100 Bramble Street

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

1.	- For State			Certific	cate of	Death		al Hygie	Reg. N	lo.	401	10	1569
R	ogietrar	e (First, Middle,Last)		Cortino				N.	ate of Death			Time of De	
i Hysician.		rancis She	eckels					M	ay 4, 2008	4c. County		Z 1Z3 III;	
2	4a. Facility Name (if	f not institution, give s	street and number)		4	o. City, Town, or Frederick	Location of	Death		Frederi			
	6111 Quinn		17.45	in yrs. last b	idhday)	If Under 1 Yea	r If Under	24Hrs. 8.	Date of Birth (/M/DD/YYY	Y) 9, Birthp	lace (State	or 1
lulleral	5. Social Security N		1			Months Day		Litin	01/11/1		Foreign Count	Maryla Iry)	and
Director	213-56-1		/ 2 F	57	Yrs.		J		01/11/				
	Usual Residence of 10a. State	10b. County	1	0c. City, Tov	wn or Location	on					10	Od. Inside (2 X No
	Maryland	Frederi	ck	F	rederi	ck							2 22 140
he Maryland tor 28a-f sh iffied at once	10e. Street and Nu					10f. Zip Code					What Country		
he Maryland a or 28a-f sh- lified at once	6111 Qui	nn Road				21701				_	States ce-America		lack
	11. Mantal Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. Wa	s Decedent of Hi es, specify Cuba	spanic Ong n, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)		ite, etc.	in indian, D	iaok,
or items 23	1 X Never Marri		1 XX Yes 2	No 7.2		Yes 2 X No	snecify.			Specify	w Whit	e	
s after	3 Widowed	4 Divorced	or Dates:	9-/3	Sa Deceden	Pe Heural Occurs	ation (Give I	kind of work		6b. Kind of	Business/Ind	dustry	
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5-0036 led within 72 hours after thygiene. other than "natural", the M dical Examiner Completed by		(First, Middle, Last)							rst, Middle, Ma				
215 be file mtal Hr rked o		lando Shec				g Address (Stre	ALIC	ce Jo	sephine	er City or T	own, State,	Zip Code)	
nould loud d Mer is man		lame/Relationship (Ty			19b. Mailin	g Address (Stre Dollyhy	de Rd	. Mou	nt Airy	, MD	21771		
MD 2 sh old 2 sh old 2 sh old 2 sh old 27 an ma	Mark Cro	onk / Frie	ena	1 20b. Pla		sition (Name of o	emetery.		ate	20c. Location	on - City or T	Town, State	
ore, ss 1 ar of Hez		Cremation 3	Removal from Sta	te cre	matory or of	herplace) n Cremat		May 6	, 2008	Frede	rick,	Mary	land
Page ment tant:	4 Donation	5 Other Specify:		Res	22.	Name and Address thaven	ss of Facilit	ty 1 C		C1-1-	at Ca	dar D	^
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Metical To Be Comple	1	uperal Service Licens			100	ini Cato	ctin	Mtn.	HWV. FT	ederi.	CK, III	$\nu = 21/2$	<i>J</i> 1
Physician	23a, Part I. Enter	the disease, comp	lications that caused	the death. D	o not enter	the mode of dyin	g, such as	cardiac or r	espiratory arre	st, shock, or	heart	Between	Onset and
/Medical	failure List of	only one cause on ea	Alcohol ad										eath
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Box 68760. Ö ۵. or Vital Records, or Attending

To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a. Certifier

(Check only one)

EXAMINER

29c. License number 20057509

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 4/28/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

DENTON MD 4629 PO BOX660

2. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DEPUTY MEDICAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OY Day **Physician** 1300A M 2008 5 Jennings Hilbert Simmons, Sr. /Medical 4c. County of Death
ORCHESTER Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DORCHESTER GEMERAL CAMBRIDGE HOSATA L 8. Date of Birth (Month, Day, NOV • 4, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1926 1 MM 2□ F Months Days Hours Min. Mary Land 213.22.4737 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 NHO Director Maryland Dorchester Bishops Head 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1851 Crocheron Rd. 21672 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Natural Resources Police CPL State of Maryland ĝ 12 permit. Pages 1 and 2 should be filed w Department of Health and Mental hygies Important: if Item 27 is marked other til any injury or other traumatic event, tin once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Simmons Alberta Creighton ည 19a. Informant's Name/Relationship (Type. Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Elaine Pritchett Simmons 1851 Crocheron Rd., Bishops Head, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State DorchesterMemorialPark 5/8/2008 Cambridge, MD 4 Donation 5 Hother (Sport ombment Signature of Fun Service Licensee ²² Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 23a Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** focumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Emboldm Sequentially list conditions, if any, leading to infriedlat cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner burial-transi monera that initiated events resulting in death) Last Due to (or as a consequence of): physician the as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy P in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has the irector, page 2 s autopsy perform 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21110 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

Brendon

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pattero



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21215-003

Baltimore, Maryland

requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

29c. License number

MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

ntini		ricasi	State of M					-		•			
		For State Registrar	State of Ma	ai yiai u	•	rtificate of	.2008	15605					
		1. Decedent's Name (First, Middle, L	ast)					2. Date of De	eath		3. Time of Death		
Physici /Medic		Frank V. S	antini					5-9-	200	Year	5:10 A M		
Examin		4a. Facility Name (If not institution, g				4b. City, Town,		eath	4c. County of Death				
		Golden Living 5. Social Security Number 6.		io (la una lant	birthdou	Frede:		rs 0 Date of Bi	Frederick				
Funeral Director		217-42-4448	1 M 2 □ F 7. Age	je (In yrs. last 64	Yrs.	Months Days		8. Date of Bi (Month, D) 5 – 16 –	1943	9. Birthplace (State or Foreign Country) 9.43 MD			
pu. N		Usual Residence of Decedent		10c. City, T	in the set of	anting				10d Inside City Limite			
faryla shov	ō	MD Fred	erick			rick				10d. Inside C			
the N	rect	10e. Street and Number	ELICK	I I	euel	10f. Zip Code		10g. Ci	tizen of What Co				
ING Z1Z13-UU36 be filed within 72 hours after death with the Maryland tital Hygiene. dother than "natural", or items 23a or 28a-f show event, it with the first in activities to be a	Funeral Director	6421 A Plant	Rd PO Box	322		2170	5		_	JSA			
ems ems	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of	Hispanic Origin'	? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - Ame Black, White			
s after	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 📉 N If Yes, Give	No		1 ∐Yes 2. No		,		Consider			
Z15-UU36 hin 72 hours aff e. an "natural", or Medical Erand		15. Decedent's	Year or Dates:	1	6a. Dece	dent's Usual Occu	pation		16b. K	ind of Business/	nite		
vithin 72 ene.	plet	(Specify only highest g Elementary/Secondary (0-12)	grade completed)		(Give life. i	kind of work done DO NOT use retire	during most of ed)	working					
XI ad with year than t, if	Completed		College (*)-4or 5	.,	So.	le Prop	rietor		Lar	nd Scap	oing ——————		
baltimore, Marylland permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 is marked oth any injury or other traumatic eventonce.	To Be	17. Father's Name (First, Middle, La. Anthony Santi					18. Mother's Ze	Surname)					
Mar d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship Margaret Cast			Rural Route Numb			Zip Code) .ckMD21705					
re, l		20a. Method of Disposition	Teman wi			Date	Town, State						
Saltimo Jermit. Pages Department of Important: If it any injury or once.		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				sition (Name of matory or other pla urg Cre		10-2008	Smi	thsbur	g, MD		
alti rmit. spartm porta y Inju		21. Signature of Funeral Service Lic			22	2. Name and Address of Facility Keeney & Basfo 06 East Church St. Frederi					ord P.A. F.H.		
D 83 E 63		John lax		101176	, 1	06 East	Churc	h St. F	red	erick,	MD 21701		
Physician		23 Part . Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		i the death. Inc.	o not ent	er the mode of dy	ing, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death		
/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	ia							
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outed ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
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e s e	dical	•	d										
ox overtiff	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	,					23d. Date of del	iverv		
Attending Physician: The law requires that the death certificate be executed activity and activity and activity and activity and activity and activity and activity and by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at] Ectopic pregnan] Other (specify) _	су			Month	Day Year		
at the	Phys	9 Unknown	9 Unknown										
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he law e has ge 2 s	ldm							- 24a. Was		prior to death?	topsy findings available completion of cause of		
clan: Ti		25. Was case referred to medical					26 Place of	1 □Yes Death (Check only	2 2 No	1 ☐ Yes	2 🗖 No		
rysick rysick iis cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ⊟ ER	/Outpatier	nt 3 🗆 DOA Ott	_	g Home 5 ☐ Res		6 ☐ Other (Spe	cifv)		
ding Ph th. After th funeral	on:T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	iry 28 y, Year)	b. Time of Injury	28c. Inju	ry at	28d. Describe					
tendi leath. Ior: A	cati	2 Accident investigati	be I				Yes 2 □ No						
lor At after of Direction by	Certification:	4 Homicide determine		ury - At home c. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location (City or To			ıral Route Number,		
DIVISION OF VIEW INCIDENCY, F.O. BOX 66 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. Whe Funeral Director: After this certificate has been signed by the aftending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying I	hysician: To the best of aminer: On the basis of	of my knowle	dge, deatl	eath occurred at the time, date and place, and due to the cause(s) and manner as stated. Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
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5 w 6 0	_	29b. Signature and title of certifier	Hay	MD	•	29c. Licen:	CLL / ~	3/-	29u. Da	te signed (Monti	- 1000		
		30, Name and address of person who	o completed cause of d	leath (Item 23	a) (Type	Print)	DITO		J.		acco		
5		Syed W. Ha	Que 7	00 n	Dar	Helain	o Hue	trederio	CK.	MD:	21701		
Sta	te	31. Date filed (Month, Day, Year)	Registra	ar's Signature	1	£ .							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008

					Olulo of W	aryian				f Death		Reg. No.		, ,	, w
			1. Decedent's Nam	e (First, Middle, I	Last)						2. Date of De	eath	V.	3. Time	of Death
	Physici		Minni	e K	ate Sch	wab					Month April	Day 17, 200	Year 8	1:45	p.m.
7	/Medic Examin		4a Facility Name (If not institution, g	rive street and number)			-		4b. City, Town, or	Location of Deal	th 4c. Cour	nty of Death		
			Colling	swood N	ursing Home	2				Rockvi	11e	Mon	tgome	ry	
	Funeral		5. Social Security N		. Sex 7. Ag	e (In yrs.	last birtl		Under 1 Yea	ar If Under 24 Hr	s. 8. Date of Bi	rth	9. Birth	nplace (State untry)	or Foreign
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	New Alend		10a. State	10b. County		10c. City	y, Town	or Location	on					10d. Inside (City Limits
	M T	호	Maryland	Prince	Georges	La	ndo	ver						1 ☐ Yes	s 2XXNo
	T 200	Director	10e. Street and Nu	mber				1	Of. Zip Code	T		10g. Citizen o	What Co	untry?	
	th with the Maryler 23a or 28e-f show	-	6103 Osb	orn Road					207	85		U.S.	Α.		
Baltimore, Maryland 21215-0020	within 72 hours effer deeth with the Maryland ene. than "naturel", or items 23e or 28e-f ehow ha Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 ☒ Widowed	ied 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:		S.			f Hispanic Origin? (uban, Mexican, Pue o <i>Specify:</i>	Specify Yes or No nto Rican, etc.)	D- 14. F	llack, White	rican Indian, e, etc. hite	
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B	end end ie m	.	19a. Informant's Na	ame/Relationship	(Type, Print)		19b.	Mailing A	ddress (Stre	et and Number or F	Rural Route Numb	oer, City or Tov	vn, State, Z	ip Code)	
Σ.	75 6	- 1	William	Schwab	(Son)		4			Road La	indover,	Mary1a	nd 2	0785	
D.C	一工を表	-1	20a. Method of Disp		☐Removal from State	20b. P	lace of lemetery	Disposition, cremato	n (Name of ry or other p	lace)	Date	20c. Locatio	n - City or 1	own, State	
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	Physician /Medical		Immediate Cause ((Cinat									1	Onset and	Death
	Examiner		disease or condition resulting in death)		aPN	EUI	101	ILA					<u> </u>		
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89	Hoet Thy	8	resulting in death) I	Last		00 00 (01	as a Co	nisoquenic	.a 01).				i		
Box	nding uses	₹			d								i		
	deeth etten ed for u	등	Part II Other eignif	icent conditions	contributing to death b	ut not resu	ulting in	the under	hina cause (niven in Part I	23h Did	tobacco use	contribute	to the cause	of death?
<u>Р</u> О	the cohe	Physician/	Tatu. Outer argini	NATIC CONGRESSION	contributing to coatri b	ut not rest	warg in	uio dildei	yang cause s	giveri ai r eat i.		Yes 2 N		obably 4	
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of Vital Records,	lew requires that the desth ce les been signed by the ettendi s 2 should be deteched for us	Completed t									24a. Was	an autopsy ormed?	a	Vere autopsy vailable prior completion of f death?	r to
Œ	The lew ste hes pege 2	ĕ									10	Yes 250 No	1	☐Yes 2	∃No
T	ysicien: The		25. Was case refer	red to medical						26. Place of De	eath (Check only	one)			
>	5 5	2	examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1 ☐ Inpatie	nt 2	ER/Out	patient 3	DOA C	Other: Nursing	Home 5 ☐ Res	idence 6 🗆 0	Other (Spec	ity)	
	er th		27. Manner of Death	h 5 ☐ Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Ti	me of jury	28c. Inj	jury at lork?	28d. Describe	how injury occ	urred		
<u> </u>	Attending or deeth. ector: After by the fune	ğ	1 Natural 2 Accident	investigati	on	, ,	***			☐ Yes 2 ☐ No					
<u></u>	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be d 28e. Place of Inj building, etc			n, street, t	factory, offic	9	28f. Location (City or To	(Street and Nu wn, State)	mber or Ru	ral Route Nu	mber,
	To the Nospital or Attending Phywithin 24 hours etter deeth. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one)		Thysician: To the best of aminer: On the basis of and manner sta	examinat									(s)
	o the ompl		29b. Signature and	title of certifier					29c. Lice	nse number		29d. Date sig	ned (Month	, Day, Year)	
	- > 1- 0) /	Pl					13	1/3)_		4/3	1/10		
	Λ		30 Name and a titr	ess of person who	o completed cause of d	eath /ttem	23a) /7	vne Print	1			1/2	100	- 8	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departmen	it of Health and M	ental Hygie	ne	15700
				e of Death		No-UUO	13/00
	Physicia		Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic		Louann Powlus Slaubaugh		May 7,	2008	<u> </u>
	Examin	er		Town, or Location of Death		4c. County of Death	
			Garrett County Mem'l Fospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	Oakland r 1 Year If Under 24 Hrs.	8. Date of Birth	Garrett	
	Funeral Director		227-92-2769 1 M XXF 51 Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, You 10/18/1	956 T	place (State or Foreign Intry) A
			Usual Residence of Decedent		10/10/1	750	
	anylan show		10a. State 10b. County 10c. City, Town or Location				10d, Inside City Limits 1 ☐ Yes 2 X No
	Ba-f	Director	WV Preston Horse Shoe		140	0	
	hours after death with the Maryland turel; or Rema 23a or 28a-f show al Examinar must be notified at			26716	109	Citizen of What Cou	intry ?
	eath ra 23	Funeral			cify Yes or No-	14. Race - Amer	ican Indian,
_	fter d	Fun	1 Nover Married 2 Married 1 Ves 2VINO	dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto f	Rican, etc.)	Black, White	, etc.
3	el', o	ρ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	2☐XNo Specify:		Specify: Whi	.te
<u>ئ</u>	be filed within 72 hours af ital Hygiene. Id other than "neturel", or event, ILa Madical Erami	Completed	15. Decedent's Education 16a. Decedent's Usu (Specify only highest grade completed) (Give kind of wo	ork done during most of working	16	b. Kind of Business/I	ndustry
2	within 72 ene. than "net	du	Elementary/Secondary (0-12) College (1-4or 5+)			T.,	_
7	Hygie Hygie other ti		17. Father's Name (First, Middle, Last)	e Salesman		Insuranc	.е
ang		Be	Harry Martin Powlus	-	Mosser	,	
Maryland 21215-0036	should be nd Mental marked c	ဥ		S (Street and Number or Rura		ity or Town, State, Z	ip Code)
	s 1 end 2 should if Heelth and Mer item 27 le marke other traumatic		Lowell Slaubaugh/Husband Rt.1 Box	256E Horse	Shoe R	un. WV26	716
ē,	ttem ttem		20a. Method of Disposition 20b. Place of Disposition (Na	me of Dother place)	ate 20	c. Location - City or 1	Town, State
Ĕ	Peges nent of ant: If it ury or o		**X**Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Texas Cemet	ery 5/10/	08 Hors	eShoeRun	, WV
Baltimore,	permit. Peges Department of I Importent: If its any injury or o		21. Signature of Funeral Service Licensee Hinkl	e Funeral H Box 186 Dav	ome. In	c.	
TI	205 2 9						
ı.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or hear failure. List only one cause on each line.	1	r respiratory arrest	'	Approximate Interval Between Anset and Death
ı	Physician		Immediate Cause (Final disease or condition resulting in death) An an an an an an an an an an an an an an)W (9			1x4 5
ı	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions.				year s
4	4	er	if any, leading to insmediate Due to (or as a consequence of).	spma			100
J.		Examin	causé. Enter Underlying Cause (Disease or injury that initiated events c.				,
/60,	te be executed ysicien and le burial-transit		resulting in death) Last Due to (or as a consequence of):				
	9 × 6	dical	d				
89 X	death certificat e attending phy id for use es th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	van
ROX	atten afor u	clan	23b. Was decedent pregnant in the past 12 months? 1	-		Month	Day Year
Ö		hysi	9 Unknown				
Č.	law requires that the es been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Ö	w require been sig should b				1 X Yes	2 □ No 3 □ Pro	obably 4 Unknown
켡		0			24a. Was an	24b. Were au	topsy findings available completion of cause of
eco	law 18s b	윤			autopsy		
al Records,	The ete h page	Completed			performe		ompletion of cause of 2□ No
Vital Recor	The ete h page	Be	25. Was case referred to medical examiner?	26. Place of Death	performe 1 Yes 2	J X iφ 1 □ Yes	2□ No
Vita	The ete h page	To Be	examiner? 1 Yes 2 Xeo Hospital: 12 Inpatient 2 ER/Outpatient 3 D	OA Other: 4 Nursing Hor	performe 1 Yes 2	1 ☐ Yes ce 6 ☐ Other (Spec	2□ No
Vita	ding Physician: The h. After this certificete h funeral director, page	To Be	examiner? 1	OA Other: 4 Nursing Hor	performe 1 Yes 2 Check only one ne 5 Residence	1 ☐ Yes ce 6 ☐ Other (Spec	2□ No
Vita	Attending Physician: The sr death. ector: After this certificate h by the funeral director, page	To Be	examiner? Yes 2 20 20 20 20 20 20 20	OA Other: 4 Nursing Hor 28c, Injury at Work? 1 Yes 2 No	performe 1 Yes 2 C Check only one ne 5 Residence 28d. Describe how	1 Yes to 6 Other (Specially) occurred	2□ No
Division of Vital Recor	or Attending Physician: The iffer death. Director: After this certificete h in by the funeral director, page	Certification: To Be	examiner? Yes 2 Yes 2 Yes	OA Cther: 4 Nursing Hor 2Bc. Injury at Work? 1 Yes 2 No	performe 1 Yes 2 Check only one ne 5 Residence 28d. Describe how 28f. Location (Stre- City or Town, s	tand Number or Ru	2□ No cify) ral Route Number,
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Vita	or Attending Physician: The ifter death. Director: After this certificete h in by the funeral director, page	edical Certification; To Be	examiner? 1 Yes 2 Noner of Death 27. Manner of Death 1 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury M 28c. Place of Injury - At home, farm, street, factor building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier	OA Cther: 4 Nursing Hor 28c. Injury at Work? 1 Yes 2 No Ty, office d at the time, date and place, and in my opinion, death occurred to License number	performe 1 Yes 2 Check only one ne 5 Residence 28d. Describe how 28f. Location (Stree City or Town, signed at the time, date	to 6 Other (Specially) occurred at and Number or Russate) se(s) and manner as a and place, and due	2☐ No ify) ral Route Number, stated. to the cause(s)
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Vita	doepital or Attending Physician: The 4 hours after death. Funeral Director: After this certificete hely filled in by the funeral director, page	edical Certification; To Be	examiner? Yes 2 No Hospital: I Inpatient 2 ER/Outpatient 3 D	OA Cther: 4 Nursing Hor 28c. Injury at Work? 1 Yes 2 No Ty, office d at the time, date and place, and, in my opinion, death occurred to License number	performe 1 Yes 2 Check only one ne 5 Residence 28d. Describe how 28f. Location (Stre- City or Town, so and due to the caused at the time, date	to 6 Other (Specially) occurred at and Number or Russate) se(s) and manner as a and place, and due	2☐ No ify) ral Route Number, stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April Physician 2'668 12:00PM Margaret Terry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glen Burnie Anne Arundel Marley Neck Health & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 23 1932 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Maryland Hours 1 □ M 2 🕁 F 75 216-28-2004 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items be notified at any or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA 5011 Corley Rd. Apt A4 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2√2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Family Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin T. Day Margaret Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other traugonce. 712 Apt B Newtowne Dr. Annapolis, Md. 21401 Alicetine Day(Sister) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 4-29-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wenname Reades of SaciliSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Reene mod 483 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) toulo **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably ☐Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Liversing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ M3 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

requires that the death certificate be executed P.O. Box 68760, Division or Vital Records,

Baltimore, Maryland 21215-0036

Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Medical

State

Registrar

erson who completed cause of death (Item 23a) (Type, Print) 600 Ridgeli

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of dertifier

Aditya Chopra M.D.
31. Date filed (Month, Day, Year) APR 2 8 2008

Avenue #231 Annapolis 32 Segistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D57028

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician $M\alpha U^{Month}$ 2008 Florence Teresa Tristani 05:01 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Havre de Grace 415 A Lafayette Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 18, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕶 F Pennsylvania 202-10-8152 87 Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 1 Yes 2 No Director Maryland Harford Havre de Grace 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ms 23a or 7 21078 U.S.A. 415 A Lafayette Street 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "y any Injury or other traumatic event, the Med any Injury or other traumatic event, the Med gones. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Eletrical Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Vietakunas Anthony Shemansky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 904 Southern Drive, Bel Air, Marylnad 21014 James P. Tristani (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Most Holy Redeemer 5/8/2008 Baltimore. MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. Ign Tuy of Funeral Service Licensee 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIME HEART Physician 10+48AR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown BPPLICABL 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYRIODYSPLASTIC SYNTROMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an page 2 s certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 31856 Sharing 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRSH P-SHARMA, MD 602 S. ATWOOD RD, BEL AIR MD 210/4

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 3 2008

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 17, 2008 4:59 P M Rose Marie Ann Van Meter April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2**X** F 77 270-26-3277 Feb. 16, 1931 Ohio Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Arnold 1 ☐ Yes 2 XNo Director or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 893 Willys Drive 21012 USA 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or itel any injury or other traumatic event, the Medical Exemine 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mazura ၉ unk Krompasky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick Van Meter/ son 893 Willys Drive Arnold, MD 21012 20b. Place of Disposition (Name of Artington National) May 08, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 2008 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atrial Fibrillation 10 years /Medical Due to (or as a consequence of): Examiner 3 months Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hypertension 10 years ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 🗆 Ectopic pregnancy Por Year Month 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed certificate 1 □Yes 2 No Division of Vital the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 【XTER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number HI 11955 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington D.C. (4 Daniel W. Carlson MD Bldg 2 Rm 4A 6900 Georgia Ave. NW

State Registrar 31. Date filed (Month, Day, Year) APR 2 8 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 12:40 P M RICHARD APRTL 26, DALE WEARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8524 POTOMAC AVE. PRINCE GEORGES COLLEGE PARK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT.23,1932 Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F 170-26-7934 Director 75 PA. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hyglene.
Inst: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show unit: If Item 27 Is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 XYes 2 No Director PRINCE GEORGES COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8524 POTOMAC AVE. U.S.A. 20740 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 TYPes 2 I No If Yes, Give 1950 – Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 TEST ENGINEER ELECTRONICS CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK. ဥ **EDNA** GRAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE WEARY/WIFE 8524 POTOMAC AVE., COLLEGE_PARK, MD. 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) GEORGE WASHINGTON CEM. 5-5-2008 ADELPHI, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licenses Chambus M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) NON-SMALL CELL LUNG CANCER 15 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed ohysician and the burial-tran Due to (or as a consequence of) Box 68760 physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 임 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 ☐ Pending investigation Iniury 1 🗌 Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Division or Vital To the Hospital or Attending Physician: hin 24 hours co.

o the Funeral Director

---olv filled in by th

State

Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

29c. License number

D26250

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

APRIL 28, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MERCANTILE LANE, LARGO, MD.

1221 MATILDA Η. SO, M.D.

31. Date filed (Month, Day, Year)

APR 2 9 2008



		State Registrar 1. Decedent's Name (First, Middle	tems 24a, 1							2. Date of D	eath	ay	Year	3. Time o	of Death
icia dica	al .	Danielle Kare								April	. 15	, 200	08	4:02	2 a M
nine	· 1	4a. Facility Name <i>(If not institution</i> Shady Grove Adv	_		a T		4b. City, Towr	or Location Ckvi		1	4		y of Death on t go!	nerv	
al or		5. Social Security Number 039-46-8146	6. Sex 1 □ M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			st birthday) 4 Yrs.	if Under 1 Ye Months Day	ar If Und	ler 24 Hrs.	8. Date of B	ay, Yea	ır)	9. Birthp Cour	place (State ontry)	
'		Usual Residence of Decedent								June 1	. 1,	1973			
	.	10a. State 10b. County		1	0c. City,	Town or Lo	cation						1	0d. inside C 1 ☐ Yes	City Limits s 2√⊡ No
	Director	Maryland 10e. Street and Number 18729 Willow	Montgomer Grove Ro			Olne	10f. Zip Cod 20832	e	<u> </u>		10g. (Citizen of USA	What Cour		
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	Be C	17. Father's Name (First, Middle,	Last)						other's Nan	ne (First, Midd					
ı	卢.	Richard Gaude						1		cesca F			2::		
ı		19a. Informant's Name/Relations Brian A. Hem		er			ng Address <i>(Stre</i> 29 Willo							,	
l	-	20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Name of matory or other	place)		Date	20c.	Location	- City or To	own, State	
l		1 ☐ Burial 2 反 Cremation 4 ☐ Donation 5 ☐ Other (5		State	l	-	litan Cı			ril 22 2008	A:	lexar	ndria	,Virgi	nia
		21. Signature of Funeral Service	Licensee		,	F1 50	Name and Ad Cancis OO Unive	dress of Fa J. Co. ersity	cility Llins	Funera	l Ho	ome l	Inc. Spring	g, MD	2090:
	edical Examiner	shock, of heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, Isaamy to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Diffu Due to b. Acut c. Acut	se Se (orasa de Bac	eptic consequence cter: consequence omeru	ence of): ial Er ewe of): uloneţ	oli ndocardi phritis	ltis		v do Action				Interval Be Onset and	
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	birth 2 nant at tii nown	Fetal me of de	death 3[eath 5[⊒Ectopic pregna □ Other (specify)				N	ate of deliv	Day	Year
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	Medical		ing Physician: To the Examiner: On the and ma		examinati										e(s)
	ğ	29b. Signature and title of certifi					29c. Lic	ense numb	er C -)	1	_		Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State	of Maryl		artment of rtificate of	Health and N Death		giene leg. No. 2	008	3 15706
		1. Decedent's Name (First, Middl	e, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
Physicia /Medica		Nancy Louise	Waggoner						2008		8:05 A ^M
Examine	er	4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location of Death		4c. Co	unty of Deat	th
and the second		11517 Durango D		7 4 //-	- I - A E - A - A - A	Lusb		T P. Data of Birth		alver	
Funeral		5. Social Security Number 213–38–3397	6. Sex 1 ☐ M 2/CX F	7. Age (in	yrs. last birthday) 67 Yrs.	Months Days		8. Date of Birth (Month, Day August 9,	Year)	Co	chplace (State or Foreign country) Shington DC
Director	-	Usual Residence of Decedent			07			August 9,	1940	VVCI	amguar ix
yland now at		10a. State 10b. County		10c	. City, Town or Lo	cation					10d. Inside City Limits
a-f sk	to	Maryland Calve	ert		Lusby	<i>!</i>					1 ☐ Yes 2 X No
th the or 28	Director	10e. Street end Number				10f. Zip Code			10g. Citizen	of What Co	ountry?
ath w	ᡖ	11517 Durango				2065				ed Sta	
er de	Funeral	11. Marital Status	Armed F		in U.S. 13.	Was Decedent of If Yes, specify Cι	Hispanic Origin? (Spuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)		Black, White	erican Indian, e, etc.
ural", or	by F	1 ☐ Never Married 2 ☐ Mar 3 🕱 Widowed 4 ☐ Divorced	If Yes. G	2 X No live Dates:		1⊡Yes 2 X N	o Specify:		Sp	ecify: W	hite
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vuld be file Mental Hy arked oth	Be (17. Father's Name (First, Middle,					18. Mother's Nam			rname)	
yid ould l Men arke	ဥ	Louis Carl Bu						ed Titus		0	7.013
Vicial d 2 sh d 2 sh th and 7 is r traum	- 1	19a. Informant's Name/Relations Lisa Greenlee		r	1		et and Number or Ru lto Road,				Zip Code)
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ages ant of tr: if it		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State M i		matory or other p hape1. Ceme	etery May 1:	3, 2008	Lusb	v. Mai	ryland
paritimiore, Index yidario A.I.Z. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	İ	21. Signature of Funeral Service		1.7		2. Name and Add		ausch Fu			
Dermii Depar Impor any ir		michael Ni	vin Ha	deni			600, Lusi	by, MD 2	0657		
		23a. Part1. Enter the disease, o shock, or heart fallure. Lis	r complications that t only one cause on	caused the	death. Do not ent	ter the mode of d	lying, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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tifficat g phy as th	ledi										
ath cer ttendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome pf pr		⊒Ectopic pregnai	ncy		230	d. Date of de Month	elivery Day Year
be dear he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		gnant at time		Other (specify)				MOUNT	Day Year
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VITAL ician: T certrificate ector, pa		25. Was case referred to medical	al				26 Place of Dea	1∐ Yes		1 ∐ Yes	s 2□No
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certify	ng Physician: To t	he best of my	v knowledge, deal	th occurred at the	e time, date and place	, and due to the	cause(s) ar	nd manner a	as stated.
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To the within Fo the	Me	29b. Signature and title of certifi	er			1	ense number		29d. Date	signed (Mon	th, Day, Year)
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		30. Name and address of person									
		Paul V. Pomill	a, MD 110	Hospi	tal Rd.	, Suite3	310, Prince	e Freder	ick,	MD 20	678
Sta Registr		31. Date filed (Month, Day, Year	2008	Hegistrar's	Signature	Me					
negisti	an .		Red.	-							

			State Registrar				Cer	tificate of	Death	1		Reg. No.	0008	1570
6			1. Decedent's Nam	ne (First, Middle, L	ast)					2	Date of De	ath Day	Voor	3. Time of Death
*	Physici /Medi		Oscar V	incent Wa	arren					A	pril	2 7	Year 2008	4:35PM ^M
	Examir		4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City, Town, o	r Location			4c. Cou	unty of Death	1100111
			Berlin N	ursing &	Rehabi.	litation	Ctr	Berlin				1	Worces	ter
	Funerai		5. Social Security I	Number 6.	Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Bir	th v. Year)	9. Birthp	lace (State or Foreign
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	pu >		Usual Residence of 10a. State	f Decedent 10b. County		100 Cit	tv. Town or Lo	agtion					4	0d. Inside City Limits
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	vith the	ä	10e. Street and Nu					10f. Zip Code				10g. Citizen	of What Cour	ntry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural"; or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral Director	8945 Bet	hel Road	1.0.111			21811				144	USA Race - Americ	- Indian
	er de Item ner n	, n	11. Marital Status		Armed F	cedent Ever in U	.S. 13. V	Vas Decedent of F f Yes, specify Cub	an, Mexica	ngin? (Specii in, Puerto Ric	y Yes or No can, etc.))- 14.	Black, White,	
36	'; or	by F	1 ☐ Never Man	ried 2 Married	If Yes, G	2 □ No Arm Sive Dates:	ıy 1	☐ Yes 🎾 No	Specify:	:		Spe	e <i>cify:</i> Bla	ack
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9	ould be filed v Mental Hygie larked other t	ပို	17. Father's Name	(First, Middle, Las	st)			MONITHE V	T *		First, Middle	, Maiden Sur		Z
an	d be ental ked c	To Be	Joseph B	riddell					Anna	a Warr	en			
₹	2 should be filed and Mental Hygical sand Mental Hygical is marked other aumatic event, the	F	19a. Informant's N		(Type. Print)		19b. Mailin	g Address (Street	1			er, City or To	wn, State, Zip	Code)
Maryland 21215-0036	nd 2:		Patricia	Warren/	wife		1	Bethel I						,
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Dis	position		20b. F	Place of Dispos	sition (Name of	>	Dat	e	20c. Location	on - City or To	own, State
no n	ages ent of rt: If i			☐Cremation 3 5 ☐ Other (Spec		n State		natorý or other pla	i i	5/02/2	nne	Unrl	oak M	D
altimore,	artme ortan injur		21. Signature of F			CIM	22	ns Cemete Name and Addre	ess of Facil	itv			ock, M	
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		1116	no be	41/19	A.	L	ewis N. V	Natson	n Fune			001	
	WINE I	-	23a. Part1. Enter shock, or he	the disease, or co	mplications that	caused the deat	th. Do not ente	618 West	ng, such as	SCALLS s cardiac or r	espiratory a	rrest.	001	Approximate
. 10			shock, or hea		y one cause on	each line.								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	on	a. Lu	of Ital	1	enal h) (Stat	×				Trees
	Examiner			4	Due to	o (or as a conse	nce.or):							
li de		ii.	Sequentially list co	onditions,	b. Due to	o (or as a conseq	uence of):							
	ted nsit	Examiner	Sequentially list co if any, leading to in cause. Enter Union Cause (Disease or	enying		(**************************************								
	and al-tra	xar	that initiated event resulting in death)	S 📰	c Due to	o (or as a conseq	juence of):							
68760,	eath certificate be executed attending physician and for use as the burial-transit													
387	icate phys s the	/Medical			d									
×	certif iding se as		IF FEMALE:		23c. If ves. o	utcome pf pregna	ancv					224	Date of delive	an.
Bo	atten for u	Physician	23b. Was deceder in the past 12	2 months?	1□Live	birth 2□Feta gnant at time of o	aldeath 3□	Ectopic pregnanc Other (specify)	У			230.	Date of delive Month	Day Year
Ö.	the d	ysic	1 ☐ Yes 2 9 ☐ Unknowr		9□Unk		JOHN DE							
P.0	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	H.	Part II. Other signi	ificant conditions	contributing to	death but not res	ulting in the ur	derlying cause giv	ven in Part	l.	23e. Did	tobacco use	contribute to t	he cause of death?
ds	signed be def	d by	Core	Man	Anden	, Uise	Depe				10	Yes 2 □ N	lo 3 □ Prot	pably 4 Unknown
Ö	w requir s been si should	Completed	ALas	1	PL	LL	C				04-14	T ₀	45. 144	P. P
ě	has has	Id I	11,40	7 01	1/2	1514K	unc	er			24a. Was	psv	4b. Were auto prior to co	psy findings available mpletion of cause of
<u>=</u>	cate page				,						1□ Yes	ormed? 2000	1 Yes	2 No
Ž.	ician: The certificate har rector, page	Be	25. Was case refe examiner?		Hospital:				200	e of Death (
Division or Vital Records,	hys this al dii	မ	1 Yes 2		1 1		ER/Outpatien	COLDON	4 NIN				Other (Specif	fy)
=	ding F h. After funera	on:	27. Manner of Dea Natural	5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time of Injury	Wo			d. Describe	how injury oc	ccurred	
Si	tend leath tor: the	cat	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not		a affairm. Affa]Yes 2□	-				
Ξ	= a = c	Certification:	4 ☐ Homicide	determine	d 28e. Plac buil	ding, etc. (Special	ome, tarm, stre fy)	eet, factory, office		281	City or To	Street and Na wn, State)	umber or Rura	al Route Number,
	urs a		00 0 0	Ha										
	Hosp 14 hor Fune fely f	ica	29a. Certifier (Check only one)	2 Medical Ex	aminer: On the	basis of examina	owledge, deatr ation and/or in	occurred at the tivestigation, in my	ime, date a opinion, de	ind place, an eath occurred	d due to the Lat the time	cause(s) and , date and pla	d manner as s ace, and due t	tated. o the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the	Medical	29b. Signature and	title of confior	and ma	nner stated.		29c. Licens	se number			29d Date of	aned (Month,	Day Year)
	A SEE		1/1/	6	1					C 3F		/		
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	SM			Forsely		use of death (Iter	n 23a) (Type, I	Print) Do	F	eunt	T.1.	JE	0 19:	744
	Sta	to	31. Date filed (Mor			Degistrar's Signa	ature	a light	7 .			70		1

DHMH 17 Rev 1/2001

State

Registrar

APR 3 0 2008

1 - For State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** BEVERLY LEE WEIMER 05 02 80 0547 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F Months Director 214-46-3580 62 Aug. 31,1945 Cumberland, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 🙀 No Director TAT 17 Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or "natural", or items 23a dical Examiner must b Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or items 23a 456 Fountainhead Drive Funeral 26726 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Completed by 3 Widowed 4 Divorced Year or Dates White er than "natur the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ James W. Wiegand <u>Doris Mae Mellotte</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is any injury or other trauonce. Michael W. Weimer/Husband 456 Fountainhead Drive Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 6 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory Cumberland, MD 2008 21. Signature of Eugeral Service Licen 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Discare OYVS Physician orunan /Medical Due to (or as a consequer of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🏋 No Year Day 4□Pregnant at time of death 5 Other (specify) Ó 9 Unknown ٦ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform ate 2 No 2 No 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

State Registrar 29b. Signature and title

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2008

31. Date filed (Month, Day, Year)

MAY 13

DHMH 17 Rev 1/2001

29c. License number

1)0033280

29d. Date signed (Month, Day, Year)

Cumberland

and manner stated.

10a5

32. Registrar's Signature

30. Name and address of Person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** April 27, 2008 2:45 A Melvin Jacob Zweig /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Manor Care Potomac Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 91 Days Hours 1**X** M 2□ F 11/7/1916 Washington DC Director 579-16-2217 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Boca Raton FL Palm Beach Director 10f. Zip Code 33487 10g. Citizen of What Country? 10e. Street and Number United States 6000 NW 2nd Avenue Apt. 234 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 4 Merchant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Bernstein Max Zweig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12029 Trailridge Drive Potcmac MD 20854 Steven Zweig - Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Adas Israel Congregation Cem Date Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐ Removal from State 4/29/08 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II70 Rockville Pike Rockville MB 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Possible **Physician** proumonia /Medical Due to (or as a consequence of): Examiner dvanu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 Tyes 2 No. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown been si should b 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? s certificate has lirector, page 2 1□ Yes 2□No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗺 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00054566

State Registrar

DHMH 17 Rev 1/2001

9801 Georgia Avenu #1-17 Silvers prince 8/10/20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Sunitua Bhogavilli

APR 2 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** J. Zickfeld 20, Apri1 2008 11:30 A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Home Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 27, 6. Sex Birthplace (State or Foreign Country)
 Illinois **Funeral** 1 ₹M 2 □ F Days Hours 88 Yrs. Director 351-03-5282 1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland 1√2 Yes 2 No Montgomery Directo Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd., # 1029 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No Navy If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Vending Manager Food Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred R. Zickfeld ပ Rose A. Grysinsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlyn R. Wolvin - Daughter 8705 Streamview Road, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Valley of the Sun
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chandler, Arizona 4/25/2008 21. Signature of Funeral Service Licenses a Name and Address of Facility neral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland Donald 20852 23a. Part1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Congestive Heart Failure 2 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No ate has b 24a, Was an autopsy performed? res 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michael a. Westerman, M.D. D52451 April 20, 2008

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 8 2008

Baltimore, Maryland 21215-0036

Vital Records, P.O. Box 68760

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Division

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael A. Westerman, M. D. P. O. Box 2316, Kensington, Maryland

20891-2316

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State of Maryland / Dep. State of Maryland / Dep. Registrar Ce	artment of Health and M rtificate of Death	Mental Hygien Rag. N	10.
I	Physicia	an	1. Decedent's Name (First, Middle, Last) William Albert Zeigler			3. Time of Death 2008 10:00a M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) Manor Care-Bethesda	4b. City, Town, or Location of Death Bethesda	4	ic. County of Death Mon Loomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 192–14–1939 1. Sex 2 F 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 21, 192	
	yland	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	he Mar 8a-1 el	ector		y Chase 10f. Zip Code	100.0	1 ☐ Yes 2 🗷 No Citizen of What Country?
	h with t	al Dir	9103 Brierly Road	20815	, ag.	USA
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "neturel", or Items 23e or 28e-f ehow event, the Medical Erapher must be multified ut	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1943–46	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 → No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hou ene. than "neture ire Medical E	Completed	(Specify only highest grade completed) (Givilenementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)		Kind of Business/Industry Insurance Company
	e filed within al Hygiene. i other than ' vent, I.e Me	a l	17. Father's Name (First, Middle, Last)	tor Group Pension 18. Mother's Name	ne (First, Middle, Maid	
ylan	should be and Mental markad o	To B	Albert Jeremiah Zeigler		E. Seip	7.0.41
Maryland	d 2 tra		1.121	ling Address <i>(Street and Number or Ru</i> 5 Dunnel Lane, Kensin g		-
Baltimore,	eg = 5		1.X.XBurial 21 ICremation 3.1 Hemoval from State 1	amatani ar athar alacol	April 30	Location - City or Town, State
Balti	permit. Pa Departmen Importent: any injury once.			Prancis J. Collins Fun 500 University Blvd, W	eral Home Ind	
	Physician /Medical bubbician and physician and physician and physician are the purial-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	nial Hemorrh		Interval Batween Onset and Death 3 Weeks
.O. Box 68760,	The law requires that the death certificate be the bear signed by the attending physicial age 2 should be detached for use as the but	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	uires that n signed t	by	Part II. Other significant conditions contributing to death but not resulting in the Encephalo path y; Respirate	underlying cause given in Part I.		co use contribute to the cause of death? 2 \(\sum \text{No} \) 3 \(\sum \text{Probably} \) Probably 4 \(\frac{4}{3} \sum \text{Unknown} \)
Records,	The law requir ate has been si page 2 should I	Completed	Encephalopathy; Respirato dysphagia, Diabetes m Coronary Arlony disease	rellitus,	24a. Was an autopsy performed 1 Yes 2 A	24b. Were autopsy findings available prior to completion of cause of death? No 1 \[Yes 2 \] No
Vital		Be	examiner?	26. Place of Dea	ath (Check only one)	
of	ding Phys h. After this funeral dii	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatin 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 Accident Accident Rospital: 1 Inpatient 2 ER/Outpatin 2 Sa. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	lome 5 ☐ Residence 28d. Describe how in	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deadlers (Check only one) 1 Certifying Physician: To the best of my knowledge, deadlers (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the To the comple	Med	20h Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	15+1		30. Name and address of person who completed cause of death (Item 23a) (Type NURUL CHOWDHURY, MD; 15216 D) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	a, Print) INO DRIVE: BUR	TONSVILL	E, M920866
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Cocath)	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar 1-Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear PM **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Months Days Hours Min 1 № M 2 □ F Yrs. 82 Director 02/02/1926 IL 349-20-7683 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No **Funeral Director** Columbia MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21046 6509 Carlinda Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 Widowed 4 Divorced 1940-1944 Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NASA College (1-4or 5+) Elementary/Secondary (0-12) Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Langille William Martin Alberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Miriam Alberg/Wife 6509 Carlinda Avenue Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☐ Burial 2 ☑ Cremation Beltsville, Maryland Chesapeake Crematory Inc. 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Sigpature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives Maryland 21286-8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic Immediate Cause (Final SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 verticulitis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Physician: The law requires that the death certificate be executed ~ I tmitis burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Minpatient Certification: To 27. Manner of Death 1 Matural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

DHMH 17 Rev 1/2001

Registrar

Medical

(Check only one)

10

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ittle

30. Name and add ss of person who completed cause of deathy) tem 23a) (Type, Print) atuxent

32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

08-03454 Ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mad Adams	1. For State	d / Department of Health an Certificate of Death		2008 15713
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month	3. Time of Death Day Year 3103 brs
ledical Examiner		Adams	May 5, 200 Location of Death	
	4a. Facility Name (if not institution, give street and numb Sinai Hospital	er) 4b. City, 10wn, of Baltimore		
Funeral	5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) If Under 1 Yea Months Day		n(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	214-81-6173 1X M 2 F	Yrs. 02 17		2008 Country) MD
any	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Location		10d. Inside City Limits
A	MD NA	Baltimore		1 X Yes 2 No
Maryland 28a-f show d at once	10e. Street and Number	10f. Zip Code		g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.	2901 Norfolk Ave		1215	U.S.A.
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be notified at once ed by Funeral Director	11. Marital Status 12. Was Decer Armed Ford		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
ter dea	3 Widowed 4 Divorced If Yes, Give Year	X No	specify:	Specify: Black
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by I	15. Decedent's Education (Specify only highest grade	completed) 16a. Decedent's Usual Occup- during most of working life	ation (Give kind of work done	16b. Kind of Business/Industry
2 3 - 6	Elementary/Secondary (0-12) College (1-4)	or 5+) N/A		N/A
5-0036 ed within 72 tygiene. other than " the Medical J	N/A 17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, M	
	William Adams		Ariana Warri	ngton
e, MD 2121 I and 2 should be fi Health and Mental item 27 is marked r traumatic event,	19a. Informant's Name/Relationship (Type, Print) Ariana Warrington-Mo	ther 2901 Norfo	${f lk}$ Ave, ${f Balti}$	nber, City or Town, State, Zip Code, more, Md 21215
ore, MD 2 shou of Health and N If item 27 is reher traumatic	20a. Method of Disposition	20b. Place of Disposition (Name of c		20c. Location - City or Town, State
Baltimore, remit. Pages I an Oppartment of Hee Important: file Important: file Injury or other tr	1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	rematory or other place) King memorial	Park 5/12/08	Woodlawn, Md
Baltimore pemit. Pages I Department of I Important: If injury or other	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	22. Name and Addre	ss of Facility	
	23a. Part 1. Enter the disease, or complications that cal	14300 Wab	ash Ave, Balt	imore, Md 21215 est. shock, or heart Approximate Interval
Physician /Medical	failure. List only one cause on each line.	fant death syndrome (SIDS		Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition resulting in death)			
<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)	onsequence of):		
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated			
d ansit	events resulting in death) Last Due to (or as a d	onsequence or):		
to, te be executed ysician and burial - transit	X UNPENDED AMENDED	erME,g880 6/21/08 TT		
760 icate b g physi the bu	IF FEMALE: 23c. If yes, o 1 Live bit	utcome of pregnancy	Ectopic pregnancy	23d. Date of delivery Month Day Year
Sox 6876 death certificate e attending phy for use as the t	past 12 months?	th 2 Fetal death 3 nt at time of death 5 Other (Specify)		
). Box 6876 the death certificat by the attending phy ched for use as the Physician/M	Part II. Other significant conditions contributing to		e given in Part I. 23e. Did t	obacco use contribute to the cause of death?
1 of Vital Records, P.O. B ling Physician: The law requires that the d After this certificate has been signed by the funeral director, page 2 should be detached on: To Be Completed by Physics		docum but not rooming in the unitarying		s 2 No 3 Probably 4 🗸 Unknown
ds, require require signal belonded			24a. Was	
Records, F The law requires fiteate has been sig page 2 should be Completed				ormed? death?
tal Rection: Tile certifical ector, pa	25. Was case referred to medical	26.Pla	ce of Death (Check only one)	
F Vits Physici r this c	1 Yes 2 No	patient 2 ER/Outpatient 3 DOA of Injury 28b. Time of Injury 28c. In	Other Nursing Home 5 njury at Work? 28d. Describe	Residence 6 Other:
n of ading I. Afte e funer	27. Manner of Death 1 X Natural 5 Pending 28a. Date of (Month,	Dav.Year)	Yes 2 No	
Division of Vital Records, P.O. Box 68760, phtal or Attending Physician: The law requires that the death certificate be executed ours after death. Beral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transi Certification: To Be Completed by Physician/Medical Ex	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At home, farm, street, factory, offic	e building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City
<u></u>	4 Homicide determined (Specify)			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		of my knowledge, death occurred at the time f examination and/or investigation, in my opin	date and place, and due to the cau ion, death occurred at the time, date	e and place, and due to the cause(s)
To To Mait	and manner st 29b. Signature and title of certifier	29c. Lice	ense number	29d. Date signed (Month, Day, Year)
W V	Mest		C.M.E. 	May 6, 2008
1 Dan	30. Name and address of person who completed cause Ana Rubio MD. Assistant Medical E		more, MD 21201	
State	16837 4 4 2000 86	gistrar's Signature		
Registra DHMH 17 Rev 1/2001		ORIGINAL		
DI HWILT LY LACY 1/2001	ı	CITIONIAL		

Anne Bend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1/11/33 State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, 2. Date of Death 3. Time of Death Last) Month **Physician** 5:30AM 2008 mie /Medical 4c. County of Death 4a. Facility Name (If not institution, give **Examiner** atonsville Ylea If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age last birthday **Funeral** 1 □ M 2 **X** F Months Days Hours -26-518 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Ptyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any liquy or other traumatic event, the Medical Experiment must be notified at once. 1 Yes 2 □ No Director tansv:lle 10f. Zip Code 10g. Citizen of What Cour Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊟Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Wigo DO NOT use retired) 16b. Kind of Business/Industry Elementary Secondary (0-12) College (1-4or 5+) omest er's Name (First, Middle 18. M lame (First, Middle, Last) Be ပ I Route Number, City or Town State, Zip Code) 19b. Mailing Address (Street and Number hmore, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enterwise disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VERALIZ MONTHS ARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MONTHS METASTA TIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 🔼 No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD

1

Registrar

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2008

Year)

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2:50 AM **Physician** 2001 /Medical 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner Sipple Birthplace (State or Foreign Country) Age (In yrs. last birthday)

5

Yrs. **Funeral** Months Hours Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show traumatic event, the Medical Examinar must be notified at 1 ₩es 2 No caltimore Director 28a-f 10g. Citizen of What Country? 10e. Street and Number ō 5206 Sipple 21206 Funeral Avenue 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 □ No or items 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 €HO Maryland 21215-0036 Specify If Yes, Give Year or Dates: Black ģ 3 Widowed 4 Divorced 1 and 2 should be filed within 72 hours Health and Mental Hygiene. 9m 27 is marked other than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Huspitalit 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Ave Baltimore, Mi) 21206 Department of Health ar Important: If item 27 is any injury or other trau once. 20a. Method of Disposition Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5.16.2008 Baltimore, MI Gregornant Cremature 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Vaugna C. Greene Francis Services 21. Signature of Funeral Service Licensee Vaughn C. Sheene 4905 York Pd East-inrore, M

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 Approximate Interval Between Onset and Death lated Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760 cate has been signed by the aftending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed' After this certificate 1 □Yes filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi

State

29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

MUG Mou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

the

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

		Registrar			Certi	ificate of	Death		R	eg. No.	000	101
Physicia		1. Decedent's Name (First, Middle, La	ast)					2.	Date of Deat Month	h Day	Year	3. Time of Deat
/Medica		Mukarram	M	irza		В	aig		05	Ŏ1	200	8 8:24p
Examine		4a. Facility Name (If not institution, given	ve street and number)		4	4b. City, Town, o				4c. Coun	ty of Deat	h
		2 Russell Ct.					timor				,	
Funeral		Social Security Number 6. 5	Sex 7.Age 1TM 2F	e (in yrs. ias		If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	Year)		hplace (State or Formuntry)
Director	-	627-24-6248 Usual Residence of Decedent	X	62	115.			1	2 01	45		India
A ++	ŀ	10a. State 10b. County		10c. City,	Town or Local	tion						10d. Inside City Lin
- F S	ğ	MD NA	Δ	1	Balti	more						X □Yes 2□
128a	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	f What Co	untry?
330	<u>ه</u>	2 Russell Ct.				212	07			U	.S.A	•
E E	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Wa	s Decedent of I	Hispanic Origi	in? (Specif	y Yes or No-			rican Indian,
tural", or items 23a or 28a-f show al Examiner runt be moltified at	교	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 Yes 2 Armed Forces?	No		′es, specify Cub ∃Yes 2 ∑ No		Puerto Hic	an, etc.)		ack, White	
<u>na</u> <u>na</u>	वि	3 Widowed 4 Divorced	Year or Dates:			1163 21 A 140	opeony.			Spec	ity: B1	ack
natro dice	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	[1]	(Give kir	nt's Usual Occup nd of work done	during most of	of working		16b. Kind of	Business/I	ndustry
han.	du	Elementary/Secondary (0-12)	College (1-4or 5	+)		NOT use retire itas S ces		tv				a
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d Me nark natic	၉				405 14:00	A.I.I (0)	1				0	
th an		19a. Informant's Name/Relationship (Mark Adams-Son	(Type, Print)	.	_	Address (Street sell C						21207
Heal em 2 ther	116	20a. Method of Disposition						Date		20c. Location		
or or or		Marial 2 ☐ Cremation 3 ☐				ion (Name of tory or other pla			i		•	
rtant Jury		4 □ Donation 5 □ Other (Special	* *	Kin		orial			08	Woodl	awn,	Md
Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, Ite Madical Event once.		21. Signature of Euneral Service Lice	2/1 mg	•	Ma'	rch F	T Wes	t			N .5	21215
	1				1/2/	OO Wah	ach A	77.0	Dalta	mara.	IVI CI	
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on each lin	ne.	Do not enter	00 Wab	ing, such as c				Ма	21215 Approximate Interval Between Onset and Death
	Exa	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	PIAC a consequer a consequer a consequer	Do not enter A R nce of): DI AL nce of): RY A	00 Wab	ing, such as c	ardiac or re	espiratory arr			Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 20b-c, perFh, g879 5/23/08 TT Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Arlan Bullock Milton 05 2008 01:11 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **X**□ M 2□ F 76 246-40-7096 Director 02 13 NC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Exp. niver must be redified at 1 ☐ Yes 2 X No Director Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1862 Dove Court 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥1Yes 2 ☐ No IfYes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington DC Dept. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Of Corrections 6yrs Psychologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be James Bullock Dorothy Hannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health ar Important: If Item 27 is any injury or other trau 21144 Nadine Bullock-Wife 1862 Dove Court, Severn, Maryland 20b. Place of Disposition (Name of Piney) expensely, crematory or other place) GATTISON FOREST 20c Location City or Town State
Rocky Mount, NC 20a. Method of Disposition 5/22/2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md Vet 5/15/08 4 Donation 5 DOther (Specify) 21. Sign store of Funeral Service Licen March F/H West 4300 Wabash Ave, Baltimore, 21215 them pour 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Chronic Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Systolic Heart Failure 24a. Was an icate has t page 2 s autopsy perform certificate 2 **X** No 1 ☐ Yes 2 ☐ No 1 TYes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this . Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t the Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Maryland 21215-0036

Saltimore.

Box 68760

P.O.

State Registrar Eric

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Lieberman MD.

Year)

D0051817

1400 Forest Glen Road #200, Silver Spring, Md 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2008 8:00 A May 10, Hugh Burton George /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 704 Orchard Overlook, #104 Odenton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 17,1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F Pennsylvania 60 493-50-3414 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Directo Odenton Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21113 704 Orchard Overlook, #104 Funeral 12. Was Decedent Ever in U.S. Aymed Forces? 12 Yes 2 No If Yes, Give Year or Dates: 1968–70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. ρ 3 Widowed W Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Director of Maintenance Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Lancy ဥ Huch Burton George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1913 Maple Street Wilmington, Delaware 19805 Kimberly Brinton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Verona, Pennsylvania Riverview Memorial Park 5/15/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 2 Thomas 1411 Annapolis Road Odenton, Maryland 21113 unnita O 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nosta k months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): -burial-1 Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

• Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and

within 2 To the 2

1271 State

Werner 900

Besignt Road #300 Annapolis, MD 21701

29d. Date signed (Month, Day, Year) 29c. License number May 12,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wen MA

31. Date filed (Month, Day, Year) MAY 1 4 2008

elmine

29b. Signature and title of certifier

29a. Certifier

Medical

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

		-	State	State of Marylan		rtment of tificate of			giene Reg. No.2	08 57 9
8	Dhusisi	301	1. Decedent's Name (First, Middle, Last)					2 Date of Dea		3. Time of Death
الأميد ا	Physicia /Medic	al	Mary Elizabeth 4a. Facility Name (If not Institution, give str			4h City Town	or Location of Death	May	4c. County	
7	Examin	er	44. Facility Name (if not institution, give sin 616 Virginia Ave			Essex			Balti	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birt (Month, Day May 19	, Year) , 1951	9. Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation			-	10d. Inside City Limits
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	or 28%	Funeral Director	10e. Street and Number			10f. Zip Code 21221			10g. Citizen of V United	
	eath v ns 23a must	eral	616 Virginia Avenue	. Was Decedent Ever in U.	.S. 13. \		Hispanic Origin? (Sp ban, Mexican, Puerti			e - American Indian,
36	72 hours after death with the Maryland inatural", or items 23a or 28a-f show dical Examiner must be notified at		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes ※XX No If Yes, Give Year or Dates:	1	ryes, specify Cu I⊡Yes 2 <mark>F</mark> N		Hican, etc.)	Specify	ck, White, etc. _{y:} White
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Baltimore, Maryland 21215-0036	Pages 1 an nent of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Real 4 □ Donation 5 □ Other (Specify)	noval from State	Place of Dispo cemetery, cres	sition (Name of matory or other p	ery 05-1	Date 2-2008		re, Maryland
Baltir	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee	70-			ress of Facility Di			of Dundalk, Inc. d 21222
	16		23a. P. rt1. Enter the disease, complication hock, or heart failure.	ations that caused the deat cause on each line.	th. Do not ent	er the mode of d	lying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	End STAG	he k	Renal	farlur	e		several year
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x 68	ertifica ling ph e as th	Medi	IF FEMALE:	c. If yes, outcome pf pregn	ancy	-			22d D	ate of delivery
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and the page 2 should be detached for use as the burial-transitions.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	⊒Ectopic pregna ⊒ Other (s <i>pecify)</i>				ate of delivery onth Day Year
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or Vital Records,	has by	Completed	multiple sc Perepheral Quadr	Neuropa	eery			24a. Was auto perf	psy ormed?	. Were autopsy findings available prior to completion of cause of death?
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i V	dilis	To B	T Yes 2D NO	ospital: 1 ☐ Inpatient 2 ☐		IR S DOA		lome 5 Res		
	ding Ph I. After th funeral	ion:	27. Manner of Death 1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Vork? □ Yes 2 □ No	28d. Describe	how injury occu	irrea
Division	I or Attending after death. Director: After din by the fune	Certification:	2 Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, st ify)	reet, factory, offi	ce		(Street and Num own, State)	nber or Rural Route Number,
0	Hospita 14 hours Funeral tely filled	edical Ce	29a. Certifier (Check only one) Certifying Phys Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at th	e time, date and plac ny opinion, death occ	e, and due to the curred at the time	e cause(s) and n	nanner as stated. e, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	V . 1 /2	, D	29c. Lic	ense number		29d. Date sign	ned (Month, Day, Year)
	/		1 Sporge	cowar s		01	6184		3/09	1/2008
***	5		30. Name and address of person who cou	mpleted cause of death (Ite	em 23a) (Type	7835 E	astpoint	mall h	1303 5	ALTIMOMO
	St	ate	30. Name and address of person who con CEO RCEN K 31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature d	sell!		-		211.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 2008 P^{M} David May 6, 1855 Woodrow /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Ft. Washington Fort Washington Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F Yrs. 11, 1918 Mississippi Nov. Director 89 428-18-7773 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1K Yes 2 No Director Port Gibson Claiborne 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA P.O. Box 81 39150 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or iten 1 ☐ Yes 2 ☐ No If Yes, Give 1943· Year or Dates: 1946 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black Specify: Completed by 3 XWidowed 4 ☐ Divorced 1946 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Magnolia Trailers Builder Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mariah Wren Dude Buck မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3900 Oaklawn Road
Fort Washington, MD 20744 19a. Informant's Name/Relationship (Type. Print) Beverly Parker-Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Buck Family 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or c 1 N Burial 2 □ Cremation 3 □ Removal from State 5-14-08 Hermanville, MS 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name and Address of Facility Robbins Funeral Home 21. Signature Funeral Service Licensee 1327 Main St., Vicksburg, MS Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ite **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner rosclerot ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ears certificate be executed tension and Due to (or as a consequence of) physician and the partiel-tr P.O. Box 68760. Physician/Medical the as attending F IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☑ER/Outpatient 3 ☐ DOA P Hospital or Attending Phys 24 hours after death. Funeral Director: After this 28d. Describe how injury occurred in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State Registrar

State 31. Date filed (Month, Day, Year)

Herber

Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 12:40 PM May 8. 2008 /Medical William Bohlaver 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2620 Keith Street Temple Hills Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 21, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**□**M 2□F Days Months Hours Virginia 579 20 2425 85 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland nat Hygiene.
And other than "natural", or items 23a or 28a-f show event, I're Marical Examinar must be retilied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adiest Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2620 Keith Street 20748 UNited States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 12 14 o Specify: Completed by White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Railroad permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Bohlayer Mildred Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William N. Bohlayer (SON) 2702 Pinewood Drive, Waldorf, MD 20601 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery, May 15, 2008 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Cer 22. Name and Address of Facility Lee Funeral Home, Inc 20735 Alexandria Ferry Road, Clinton, MD surran M00257 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INFARLTION /Medical Examiner OSCLEROTIC (ARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I∐Yes 2∏No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🎇 No page certificate 1 ☐ Yes 2 ☐ No or Attending Physician; director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 2 Accident 5 Pending ours after death.

eral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a, Certifier 1 XX certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) D 30583/MD May 12, 2008 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print) John N. Van Dam, M.D., 3508 Old Silver Hill Road, Suitland MD 20746 31. Date filed (Month, Day, Year) 32. Registrar's Signature State South . Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28b pr me, g879, 05/14/03dhb Reg. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Ye ar **Physician** :36 A M BENIGNA BRANDL MARY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABALLMORE 9. Birthplace (State or Foreign Country)
Germany 8. Date of Birth (Month, Day, Oct. 20 Funera! Days Months 1 ☐ M 2 🗓 F 217-74-4486 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 🗓 No Funeral Director Baltimore Baltimore ${ t Maryland}_{ t }$ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21212 U.S.A. 6401 N. Charles Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after di Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, I're Medical Everting. onge. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sacristan/Seamstress Religious 4 years 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ Sabina Meier Brand1 Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21212 Sr. Patricia Glinka, S.S.N.D. 6401 N. Charles Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Arm, Maryland Villa Maria Cemetery 5-12-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Şervice Licensee ²²Mitchell wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** ERRITRATION APPROVED BY MEDICAL ELAMINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical for use 23b. Was decedent pregnant in the past 12 months? If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be def significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 25. Was case referred to medical examiner?
1 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Fall at hom 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation n 24 hours after death.

Per Funeral Director: Af bletely filled in by the fun 1 ☐ Yes 2 No 5-5-08 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 401 N Charks St, Balhmon 11 21212 nome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAUTIMORE OF BAUTIMORIF

State

Registrar

31. Date filed (Month, Day, Year)

MAY 14 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth May **Physician** "12, 4:30 M L. Baum Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner P.G. Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 8, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 X M 2 □ F Months Days Hours Min. Missouri 1918 89 Director 495 05 8192 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director MD P.G. Upper MArlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 9507 Nottingham Drive USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 ☐ Never Married 2 🙀 Married Saltimore, Maryland 21215-0036 1 □Yes XX No White Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Rufus Ida Mae McCann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Baum (Wife) 9507 Nottingham Drive, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery May 15,2008 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Approximate Interval Between Onset and Death Alexandria Ferry Rd, Clinton, MD Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final cute **Physician** ouges disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VOWAVY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse n ence of): Examiner certificate be executêd burial-transit ereusion and Due to or as a consequence of) Box 68760, attending physician for use as the buria 008 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) □Yes 2□No P.0. the detached 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 70 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy After this certificate 1 □Yes 1 ☐ Yes 2 ☐ No 2 **H**O 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Appatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2008 1042049

Registrar

State

31. Date filed (Month, Day, Year)

Alain Champaloux,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD. 14314 Old Marlboro Pike , Upper Marlboro, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death

SALTIMORE

Day

Year

2008

4c. County of Death

Physician /Medical Examiner

Funeral

Director

4a. Facility Name (If not institution, give street and number,

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ms 23a or 7

3altimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-transit signed by the a page 2 the Hospital or Attending Physician: funeral director, 24 hours after death e Funeral Director:

Division or Vital Records, P.O. Box 68760,

5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7, 2008 9. Birthplace (State or Foreign Months Days 1 **∑** M 2 □ F Hours 46 Maryland Yrs none Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Directo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 873 New London Harbor USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be AMelia Brannock P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Univeristy of Maryland Hospital 22 S. Green Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☒Other(Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pa 11. Enter the dileas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Vause (Final Approximate Interval Betwood disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant condition 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performe Yes 2 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient ဂ 2 ER/Outpatient 3□ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene S

State

Registrar

31. Date filed (Month, Day,

Year)

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2008

within 24

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Lest) 3. Time of Death Month **Physician** 800 05 06 2008 1 Chae Thone /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Medical Mars marc If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 2 Min. 1⊠ M 2□ F Director none May 6, 2008 Maryland Usuel Residence of Decedent death with the Marvlend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show mant be notified at MD Anne Arundel Pasadena 1 ☐ Yes 2X ☐ No Funeral Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 873 New London Harbor 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status parmit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than 'natural', or item any injury or other traumatic event, the Market and once. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) unk Be Amelia Brannock 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) University of Maryland Hospital 22 S. Green Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☒ Other (Specify) in State 21. Signature of Eun ral Service Linsee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the deeth certificeta be executed use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. attending physicien Due to (or as a consequence of) signed by the at 1 be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes PLA To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□**-No 1 Dincetient 2 ER/Outpatient 3 DOA eral Director: After this filted in by the funeral di 27. Mannes of Death Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Laturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral D Medicai (29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Che To the 29b. Signetur 29c. License number 29d. Date signed (Month. Day, Yeer) 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 225 Grene St Janna dd 32 Registrer's Signetur 31. Date filed (Month, Day, Year) State MAY 1 4 2008

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BURON 05 10:00 AM MY OTTO 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 101 Center Place #915 Baltimore Dunda1k If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 2, 1936 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1⊠M 2□F 62 Canada 562-60-1130 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Center Place #915 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 Divorced "natural" other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Be Samuel Buron Emma Schmidt ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i Susan Kastina/res coor 915 Center Place Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1.
Department of He
Important: If Iten
any injury or oth 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature of Funeral Service lice Ronald 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street . Wade Director Baltimore, MD 21201 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CARDIAC ARRHYTHMIA MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the a 9 H Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEIZURE DISURDER 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes or Attending Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HA BALTIMORE ENNIFER 415H1 5505 HOPKINS BAYVIEW CIRCLE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 14 2008 Registrar

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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of De		4c. County of Dea	
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34	Funeral Director		5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year Months Days			9. Bi 1915 Mar	nthplace (State or Foreign ountry) yland
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စ်	Heal Heal tem 2		20a. Method of Disposition		. Place of Dispo	sition (Name of		Date Date	20c. Location - City o	r Town, State
OL.	ages ant of it: If i		1 ☐ Buriaf 2 ☐ Cremation 3 ☐ 4 🕅 Donation 5 ☐ Other (Specify		cemetery, crea	matory`or other pla	ice)			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tra		21. Signature of Emeral Service Ucen						. Baltimor	e Street
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical (29a. Certifier Check only one)	ysician: To the best of my niner: On the basis of exam and manner stated.	ination and/or in	ivestigation, in my	opinion, death of	curred at the time, o	late and place, and du	e to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier		1."	29c. Licen	se number	2	29d. Date signed (Mor	nth, Day, Year)
1			· //	Attend	hy mo	0	37016		may 7,	2008
			30. Name and address of person who o	completed cause of death (Item 23a) (Type,	Print)	-1 1	\ U	0 1/	21204
			1.0	me, ms 6-	tol N.	(Lever)	th, sh	te 7/05	1 13.177M	and mo
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #26 Per Verbal G8/9 115/08 JH Reg. No. Reg. No. 3. Time of Death 2. Date of Death Physician 12:33AM 00 K 2008 /Medical 4c. County of Death or Location of Death (If not institution, give street and number) Examiner Raltimore tospita Istow Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Month, Day, Days 1 □ M 2 💢 F Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Woodlawn 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 21207 lownbrook Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working cordary (0-12) College (1-4or 5+) omestic omes 18. M her's Name (First, Middle, Maiden Surname Father's Name (First, Middle, Last) Be ပ 19b. Mailing Addess (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Pgnt) Balto. Lonya A. Wiggins
20a. Method of Disposition 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner sician and burial-trans t The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the and d be detached for 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
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To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 🗌 Yes 20 No 2 XXR/Outpatient 3 DOA 1 🔲 Inpatient P 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -13-08 Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 1501 DIVISIONST MD State Registrar

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State of Maryland / Department of H	Health and Menta	I Hygiene

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	s 1 an f Heal Item		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other p	lace)	Date	20c. Locatio	n - City or T	own, State
E	Page nent o int: If iry or		1, ☐ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special		New Cathe		I	^{lay} 2008	Balti	more,	MD
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Box	The law requires that the death certit lie has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No}\)		2 Fetal death 3	∃Ectopic pregnar ∃ Other <i>(specify)</i>				Month	Day Year
P.0	t the by the tacher	hys	9 Unknown	9□ Unknown							
	es tha	þ	Part II. Other significent conditions	ontributing to death b	ut not resulting in the t	inderlying cause	given in Part I.				the cause of death?
Records,	w requir been si should I	Completed							Yes 2□No		
3ec	e law has b	mple						24a. Wa:		b. Were autoprior to co death?	opsy findings available ompletion of cause of
al			85 W					1 □ Yes	2 No	1 Yes	2 No
Vital	Physicisn: The this certificete har director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3 DOA	Ither	of Death (Check only sing Home 5 Res		Other (Speci	ifv)
J of	ਦ ਦੁ ख	-	27. Manner of Death	28a. Date of Inju	ry 28b. Time o			28d. Describe			197
ior	Attending Ph r death. ector: After th by the funeral	atio	1 Natural 5 Pending investigatio	n	y roary injury		Yes 2 N	lo			
Division	I or Attendate after death Director:	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, st c. (Specify)	reet, factory, offic	8	28f. Location City or To	(Street and Nu wn, State)	m <i>ber or Rui</i>	rel Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Pi	vsician: To the hest	of my knowledge, deat	h occurred at the	time, date and	place, and due to the	causa(s) and	manner as	stated.
	To the Hospitel within 24 hours a To the Funeral Completely filled	edical			examination and/or in						
	To the To the comp	Σ	29b. Signature and title of certifier			29c, Lice	nse number	7	29d. Date sig	ned (Month	Dey, Year)
	4.		1 Chin	٧		D	401	0.1	5	112	002
12	Y		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type,	Print)	ain IL	"Hzno	Clen	2,,,,,	è,140 2106
	Sta	te	31. Date filed (Month, Day, Yeer)	32 Registr	ar's Signature		ידוו ן דונ	00017	CULL	UVIII	5/11/0 C100
	Registr		MAY 14 20	108	a Si fay	action of					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death Date Month 75, 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2008 **Physician** May 8:05 A Gary Cockrill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner New Annapolis Nursing Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, May 23, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 🖾 M 2 🗆 F 47 1960 Maryland 214-84-2207 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State show d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1792 Bay Ridge Ave. 21403 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ∐Yes 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify Specify: White þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation .. Pages 1 and 2 should be filed wir tment of Health and Mental Hygien tant: If item 27 is marked other th ijury or other traumatic event, Ital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Shirley L. Rogers Charles W. Cockrill, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Cockrill, Jr./ Bro. permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 527 Point Field Dr., Millersville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Catonsville, Maryland 2008 Metro Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, 21. Signature of Funeral Service Licensee Kudarels MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOVENTRICULATION SYNDROME /Medical Due to (or as a consequence of) **Examiner** EXOGENUS OBESITY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) □Yes 2□No P.O. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 □Yes 2 No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely (Check only one) the the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0026024 May 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Varnum St. Washington, D.C. 20017 Lester Miles, M.D., a2. Registrar's Signature 31. Date filed (Month, Day, Year) NAY 1 4 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** oro thy COOPER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hilare Center Baltimor Keswile If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
6-17-1908 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 F Director 213-26-2305 99 Usual Residence of Decedent 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A Baltimore MD Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA W. 40th 700 Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: Black 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private Homes Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker 4th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland William Spence Blanche Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce. Haynesville, VA 22472 P.O. Box Anna Thompson -Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-16-2008 Laurel, MD MD National 4 Donation 5 Other (Specify) March F/H East 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 la Wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Athorschrotic Immediate Cause (Final Physician Colonny disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 thknown Completed 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 | Yes 2 | ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

5-12.04

Baltimer mo

XXYes 2 No

08

Black, White, etc.

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred **≯** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

32. Reistrar's Signature 2008

107

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

or Attending

hours after death.

24 hours a Funeral I

the

filled in by

completely

Medical

29b. Signatyne and title of certifier

31. Date filed (Month, Day, Year)

COPE

29c. License number

00059189

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11 4 SDM MA Vincent Frank Cascio 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMONE If Under 1 Year | If Under 24 Hrs. SAINT AGNES HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 X M 2 □ F Maryland 1, Director 213-05-1858 Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be USA 21228 709 Maiden Choice Lane RG403S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 1 1 2 1 1 No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or itel ury or other traumatic event, the Medical Externiner 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Engineer Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Serio Antonio Cascio မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 707 Longview Drive; Catonsville, Maryland 21228 Son Anthony Cascio 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland Lake View Mem. Park 5/16/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS HOURS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed icate has been s 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No HTPOTHYROIDISM 24a. Was an autopsy performed? certificate 2 000 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 일 1 Yes 2 No 1 dppatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

NOAM

The law requires that the death certificate be execu Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours a let deam.

To the Funeral Director.

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

11,2008

MD 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

AVENUE, BALTIMORE MO 21229

2. Registrar's Signature 900 ofosu , M

and manner stated.

P 21617

		For State Registrar	te of Maryland / Dep Ce	partment of He ertificate of De		ntal Hygien Reg. N	4000	15733
Physici		1. Decedent's Name (First, Middle, Last) Marvin K. C	larke			Date of Death Month May 10,	^{ay} 2008 ^{Year}	3. Time of Death 8:55a M
/Medic Examin		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Lo			c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 112 M 2	7. Age (In yrs. last birthda 82 Yrs.	y) If Under 1 Year t	f Under 24 Hrs. 8.	Date of Birth (Month, Day, Yea an 15, 19	9. Birti 926 M	nplace (State or Foreign untry) D
uyland show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or		7.7			10d. tnside City Limits 1 ☐ Yes 2 ☑ No
vith the Ma or 28a-f	Directo	MD Carroll 10e. Street and Number		Sykesvi		10g. C	itizen of What Co USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours atter death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinal must be ricitified at once.	by Funeral Director	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces? Yes 24 No es, Give ar or Dates:	2178 3. Was Decedent of Hisp tr Yes, specify Cuban,	anic Origin? (Specif	ly Yes or No- can, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036 Id 2 should be filed within 72 hours att th and Mental Hygiene. It is marked other then "neturel", or traumatic event, the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Gir	cedent's Usual Occupation of work done dure to NOT use retired) Farmer	on ing most of working		Kind of Business/	·
and 2 d be filed a antal Hygic ted other c event, II	Be	17. Father's Name (First, Middle, Last) Marvin B. Clark	e		8. Mother's Name (A	First, Middle, Maide		
Marylanc	은	19a. Informant's Name/Relationship (Type, Pri Mrs. Debbie Parker (19b. Ma	diling Address (Street and	d Number or Rural F	Route Number, City		Zip Code)
altimore, mit. Pages 1 en partment of Heel portant: if Item 2 y Injury or other		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dis	position (Name of rematory or other place) hape1 Cemet	Dat	e 20c.	Location - City or kesville	
Balti permit. Departn Imports eny inte		21. Signature of Funerat Service Licensee	eft MOOKY	22 Name and Address HAIGHT FUNE PO Box 195	of Facility RAL HOME Sykesvill	& CHAPEL e. MD 21	, P.A. 784	
Pnysician /Medical	a U	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Do not e	enter the mode of dying,				Approximate Interval Between Onset and Death
Examiner	liner	Sequentially list conditions b	Due to (or as a consequence of).	Mass				3 monts
58760, licate be executed physicien and s the burial-transit	dical Examiner	that initiated events c.	Due to (or as a consequence of):	/ I リ				
I Records, P.O. Box 68 The law requires that the death certilica ate hes been signed by the ettending ph bage 2 should be detached for use as th	Physician/Medi	in the past 12 months?		3 Ectopic pregnancy 5 Other (specify)			23d. Date of del Month	ivery Day Year
rds, P. quires that n signed by	þ	Part tl. Other significant conditions contribution	ng to death but not resulting in the	underlying cause given	in Part I.			the cause of death?
	Completed					24a. Was an autopsy performed?	death?	utopsy findings available comptetion of cause of
f Vita ysiclan: is certific director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospita	t: 1 Inpatient 2 ER/Outpat		26. Place of Death (6 DOther (Co.	-4.)
Vision of Vita Attending Physician: of death. ector: Atter this cartifici by the funeral director.	tlon: To	27. Manner of Death 1 Natural 5 Pending	Date of Injury (Month, Day Year) 28b. Time Injury	o of 28c. tnjury a Work?		d. Describe how in		ciry)
Divisi	Certification:	a Could not be	Place of tnjury - At home, farm, building, etc. (Specify)	street, factory, office	28	f. Location (Street City or Town, Sta		ural Route Number,
Division (To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely tilled in by the funer	edical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, de the basis of examination and/or d manner stated.					
To th within To th compl	Me	29b. Signature and title of certifier	10	29c. License r	52035		Date signed (Mont	h. Day, Year) 200 S
10		30. Name and address of person who complete	d cause of death (Item 23a) (Type 291 Stone v	n Deine)			1157	
Sta Registr		31. Date filed (Month, Day, Year) MAY 14 2008	291 Stoney 32 Registrar's Signature	garle)				

AMAND TITM TO THE COLOR TO THE STATE OF MAIN AND MENTAL Hygiene? () () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Robert Clayborne Cassell May 2008 11 3:45a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Taneytown Carroll Lorien Nursing Center- Taneytown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 215–30 – 7878 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□F Months VA Director Ju<u>ly</u> 28 1933 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD Carroll Sykesville 1 ☐ Yes 2√ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7515 Dogwood Road 21784 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 27 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evanterions. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white 3√ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) transportation professional truck driver 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry Herbert Cassell Ruby Catherine Gollehon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Cassell (daughter) 116 E. Broadway St., Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Springfield Cemetery 5-17-08 Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paigesfaig C tens P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on our line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical (or as a consequence of) Due ! Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 pe lan/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Physic 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown cate has been sig Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Victory Street ed cause of death (Item 23a) (Type, Print) 3337 31. Date filed (Month, Day, Year) 36. Registrar's Signature State 1 4 2008

Registrar

Value A. Childs May 2,2008 12574 Baltimore, Maryland 21215-0036

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tal Records, P.O. Box 68760,	n; The law requires that the death certificate be executed
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		Registrar 1. Decedent's Nam	ne (First, Middle, L	ast)		Ce	rtificate o	i Death	2. Date of D	Reg. No.		3. Time of De
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i	Director	10e. Street and Nu	ımber				10f. Zip Code	e		10g. Citiz	zen of What	Country?
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DHMH 17 Rev 1/2001

1 - For State Registrar

SINAL

GLORIA

5. Social Security Number

213-28-4561

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

MAY

4a. Facility Name (If not institution, give street and number)

6. Sex

HOSPITAL

DABBS

OF

1 □ M 2 🛣 F

BALTIMORE

7. Age (In yrs. last birthday)

79

10c. City, Town or Location

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7	036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 □ Never Mar 3 □ Widowed	ried 2 A Married 4 Divorced	1 ☐ Yes 24⊡ I If Yes, Give Year or Dates:	No		1 ☐ Yes	¾ □ No	Specify:			
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	al Records, P.O. Box 68760, ≪	n: The law requires that the death certificate be executed ficate has been signed by the attending physician and or, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome								
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	٥	Attending Physician: The law requires that the death cer cleath. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	n:	27. Manner of De		28a. Date of Inju		28b. Ti	ime of jury	28c. Inju Wo	ry at rk?	280	d. Describ	e how
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		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)	2 Medical Exa	rnysician: To the best aminer: On the basis of and manner st	of examina	ation and	d/or investigati	on, in my	opinion, death	occurred	at the tin	ne, date
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 3. Time of Death 2. Date of Death Day Year 4:52 PM 9 MAY 2008 4c. County of Death CITY 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 3/17/1929 SUMTER, SC 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: BLACK Kind of Business/Industry ALTIMORE CITY den Surname) ΕN ity or Town, State, Zip Code) ORE, MD 21215 . Location - City or Town, State BALTIMORE, MD NERAL HOME E, BALTIMORE, MD Approximate Interval Between Onset and Death BAY 23d. Date of delivery co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No d? No e 6 □Other (Specify) injury occurred t and Number or Rural Route Number, State) se(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year) 9, 2008

BACTIMORE

Registrar

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. | Hours | Min.

BALTIMORE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** \mathbf{P}^{M} 2008 FAY DORSEY MAY 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 6435 BOCK ROAD OXON HILL 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Funeral Days Hours 1 □ M 2 🗶 F Yrs. Director 577-96-2532 43 DEC. 25, 1964 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director PRINCE GEORGE'S OXON HILL MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20745 USA 6435 Bock Road Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed Medical 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the 11th Day Care Provider Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence E. Dorsey Mary L. Proctor ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Dorsey / Mother 6435 Bock Road Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or otl 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 05-15-2008 Clinton, MD of Funeral Se 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD 20746 Donald R. Gray 6 23a. Part Enter the disease, o shock, or heart failure. Lis plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 1CIUO WO Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) death certificate be executed burial-transi Exami and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buris Physician/Medical as the l IF FEMALE asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Yea 5 Other (specify) signed by the a 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page this certificate 1 Yes 2 X No Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗆 Yes 2 No 1 🔲 Inpatient 3 DOA P 2 ER/Outpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Natural (Month, Day Year) 5 Pending Injury within 24 hours after death.

To the Funeral Director: At, completely filled in two. 1 □ Yes 2 □ No M investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 6046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

M. ALIKHANI

MAY

31. Date filed (Month, Day, Year)

LA PLATA, MD

5 GARRETT AVENUE

32 degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03414 State of Maryland / Department of Health and Mental Hygiene Muriel Denise Dixon Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 4, 2008 1552 hrs Medical Examiner MURIEL DENISE DIXON c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles La Plata Civista Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. If Under 1 Year 5. Social Security Number 6 Sex **Funeral** Min. Months Days Hours 06-22-1970 Director Country) 37 218-98-8062 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No : 23a or 28a-f show : notified at once. CHARLES WALDORF MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 4016 BLUEBIRD DRIVE USA 20603 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 X No Yes Specify: f Yes, Give Year Yes 2 X No specify: BLACK 3 Widowed 4 X Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 ADMINISTRATIVE COORDINATER PRIVATE 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brenda Nunn Be Clark Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 903 Chatsworth Drive Accokeek, MD Brenda Bradford / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) permit. Pages 1 a
Department of H
Important: If it 1 X Burial 2 Cremation 3 moval from State 05-10-2008 Suitland, MD **Washington National** Donation 5 Other Specify. þ 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licen Suitland, MD 20746 Donald R. Gray 4308 Suitland Road Approximate Interval cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or co failure. List only one cause **Physician** Between Onset and Medical Death Seizure Disorder Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 23a, 27 per MEO G-880 6/16/08 reb signed by the attending physician be detached for use as the burial -Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? After this certificate has performed? 2 No Yes 2 No ✓ Yes 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other: examiner? Hospital: Nursing Home 5 Residence 6 Other: 2 CER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

n 24 hours after death.

te Funeral Director: A letely filled in by the fu To the I within 2 To the I

uu

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number 29d. Date signed (Month, Day, Year) May 5, 2008 O.C.M.E.

OCME

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

. Registrar's Signature

			1- State of Maryland / Depa	rtment of Health and M	lental Hygiene Reg. No	4000 10100
Ç.	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month Date	3. Time of Death
1	/Medic	_	Opal Thomas Duncan	4h Oity Tayya and postion of Dooth		008 8:08 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		altimore
_ ×	Funeral		3202 Grace Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Edgemere If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
н	Director		219 - 50 - 7212	Months Days Hours Min.	(Month, Day, Year 05-03-191	
	pui N		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	/aryla	ō	Maryland Baltimore Edgemere			1 ☐ Yes 27 No
	the 128a-notifi	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	h with	E D	3202 Grace Road	21219	Uni	ted States
	ems a	Funeral I	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	safter or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Yes 25 No Specify:	·	Specify: White
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	q pa	3€XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedenty	lent's Usual Occupation	16b. l	Kind of Business/Industry
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yla	d Men narke natic	٩	Joseph Thomas Mahoney	Pet Wayr		ar Tawn State 7in Code)
Maryland	d 2 sh th and th sh traur			Markham Ct. Apt. N		Maryland 21014
ē,	f Heal f Heal tem 2 other		.,			Location - City or Town, State
9E	Pages ient o nt: #1			Memorial Gdns 05-1	L5-2008 Bel	Air, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Euneral Service Licensee	Name and Address of Facility		
<u>m</u>	99 E # 9		1900 A	lda-Ruck Funeral F 22 Wise Avenue Di	indalk, Mai	Approximate Interval Between
68760, 🖈	death certificate be executed Medical Examiner e attending physician and dior rase as the buriar-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Here to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of):	erios elenatic Car	J,O Dascular	i visea so
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.O. Box	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	·= 0 -	þ	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2□ No 3□ Probably 4∰Unknown
I Records,	The law ate has b page 2 st	Completed			24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No
or Vital	Jing Physician; Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	h (Check only one)	
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on	Attending F r death. ector: After by the funera	tion	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident Investigation	28c. Injury at Work? M 1 Yes 2 No	,	,
Division	i ji fi e	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl 2 Medical Examiner: On the basis of examination and/or in and manner stated.	rred at the time, date a	nd place, and due to the cause(s)	
	To t To t	M	29b. Signature and office of certifier.	29c. License number) 18667		y 10 , 2008
	P		39. Name and address of person who completed cause of death (Item 23a) (Type, Philip Militello, MD (e Tr	D 18667	yther ville	Md 21093
	Sta Regist		31. Date filed (Month) Day, Year) 32. Tegistrar's Signature			-
01	IMH 17 Rev 1/2		MAY 1 4 2008 Street & Ay			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** DeCerbo 9:50 PM 11, 2008 Α. Laura May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Essex Riverview Nursing Home 8. Date of Birth (Month, Day, Year) May 25, 1924 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 € F Yrs Maryland Director 83 218-18-8042 Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be rediffed at Dundalk 1 ☐ Yes 2X No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 6927 Broening Road United States 21222 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or itee iry or other traumatic event, Item Pagical Exercitival. 1 ☐ Yes 2/XNo If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXXNo Specify. Specify: ۾ 3 Widowed 4 Divorced White Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nina Cafanna Jesse Trapani ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Mr. Anthony DeCerbo (Son) 9111 Bowline Road Baltimore, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith Cem. 5/15/2008 5 ☐ Other (Specify) 4 ☐ Donation Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1) emanto Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

15 Honeral Director: After this certificate has been signed by the attending physician and easily filled in by the funneral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed ann a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed? 1 ☐Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1.☑Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 2 To the 29c. License number D - 3 8 7 5 4 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MALIKA WASIEM. 709. Er STERN BLUD. MD-21221. 709. egistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 5/4 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5 200 **Physician** 0 G Dameron Fredorick /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore ot Marylan Univ. If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, Year Mar. 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 X M 2 ☐ F 1921 Director 87 578-16-8143 Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a State 10b. County r then "natural", or iteme 23a or 28a-f ehow the Medical Exempler must be notified at 1 Yes 2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21085 703 Falconer Road e filed within 72 hours after death if Hygiene. other then "natural", or Iteme 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Steel Manufacturer 12 Blast Furnace Operator 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny injury or other traumatic event sing. 17. Father's Name (First, Middle, Last) Be Della (unk) Nethery Edward G. Dameron 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 703 Falconer Road, Joppa, Maryland 21085 Helen Dameron / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) Hilltop Service Corp. 5-13-08 Towson, Maryland 21. Signature Funeral Service License McComasdoFurieral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dans hamothorax Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury PROVED BY MEDICAL EXAMINI Due to (or as a Examine requires that the death certificate be executed the burial-transit +1 050 that initiated events resulting in death) Last physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 22 No 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Passeinger funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 29b. Time of 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 📋 Yes Motor valuada Collision death. investigation 3 41 05-64-2008 al or Attend after death Director: 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Jown, State)

28f. Location (Street and Number or Rural Route Number, City or Jown, State)

28f. Location (Street and Number or Rural Route Number, City or Jown, State)

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28f. Location (Street and Number or Rural Route Number)

28f. Location (Street and Number or Rural Route Number) 6 Could not be determined 3 □ Suicide 4 - Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month.

30. Name and address of person who ampleted cause of death (Item, 3a) (Type, Print)

la

22

2. Registrar's Signature

29d. Date signed (Month, Day, Year)

			for State Registrar	State	of Maryla	and / Depa <i>Cel</i>	artment of rtificate o				giene / Reg. No.	2008	15742
			1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea		Vans	3. Time of Death
	Physici /Medio		Salah				Elshar	nawa	ny	05	12 Day	2008	5:00p M
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town	, or Locat	tion of Death		4c. County of Death		
i ma			9209 Quick F	ОX			Co	luml	bia		Howard		
F	Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Yea		nder 24 Hrs. urs Min.	8. Date of Birt	8. Date of Birth (Month, Day, Year) 9. Birthp		lace (State or Foreign
D	Director	L	224-96-1842	1 X M 2□F	72	Yrs.	Months Day	/S HOL	uis wiii.	12 22	36		
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aryla	shov	<u>_</u>	10a. State 10b. County		100.	City, Town or Lo						1	1 ☐ Yes 2√☐ No
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er de	item	Ë	11. Marital Status 1 □ Never Married 2 □ Married	Armed F	cedent Ever in forces? 2 T No	U.S. 13.	Was Decedent of f Yes, specify C	uban, Me	c Origin? (Sp xican, Puerto	ecity Yes of No- Rican, etc.)	14	I. Race - Americ Black, White, e	
d 21215-0036 filed within 72 hours after death with the Maryland	r, or		Widowed 4 □ Divorced	If Yes, G	iive 🔨		1∐Yes 2 X ∏N	lo Spe	ecify:		S	pecify: Whi	te
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21215-0036 d within 72 hours aft	in in	ple	(Specify only higher Elementary/Secondary (0-12)	<u> </u>) (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during ired)	most of worki	ing			
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	യ യ ≍		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Stre	eet and Nu	umber or Rur	al Route Numbe	er, City or T	Town, State, Zip	^{Code)} 21045
	Health lem 27 i other tra		Adel Alalfey	-Brother	s-In I	aw 684	6 Sewe	ells	Orch	ard Dr	., C	olumbi	a, Md
ore s	r oth		20a. Method of Disposition		201	D. Place of Dispo cemetery, crer	sition (Name of natory or other p	olace)		Date	20c. Loca	ation - City or To	wn, State
Pag P			1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	ng Mem			k 5/1	3/08	500W	lawn.	МА
Balt permit.	Department Important: I any injury c		21. Signature of Funeral Service	Licensee		22	Name and Add	dress of F	acility	3700 1	wood	Tawn	
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/ 10	+	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or se a cone	squerice of):							
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8760, cate be executed	physician and s the burial-transit	dical		d									
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Box	attending p for us e as	sician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pred birth 2 F	etal death 3 [Ectopic pregna				23	d. Date of delive	ery Day Year
o e de	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pre	gnant at time (nown	of death 5	Other (specify,)			}	WOTH	Day Teal
J. #	d by etach	Phys		no contribution to	looth hut not a	noulting in the co		airen in D	lout I	220 Did to	hann una	a contribute to th	ne cause of death?
Hecords, P.O. Box 6 he law requires that the death certifi	been signed by the should be detached	þ	Part II. Other significant condition	nis contributing to t	leath but not i	esuling in the ui	idenying cause	given in P	arti.	1 Z Y			ably 4 \ Unknown
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o §	2 2	Completed								24a. Was a	an sy	24b. Were auto	psy findings available npletion of cause of
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VI tal sician: ⊺	sertifi actor,	Be	25. Was case referred to medical examiner?						Place of Death	(Check only o	ne)		
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DIVISION I or Attending	Direc in by	Certification:	4 ☐ Homicide determ	ined 28e. Plac	e of Injury - At ling, etc. <i>(Spe</i>	home, farm, streecify)	et, factory, offic	e		28f. Location (S City or Tow	Street and l n, State)	Number or Rura	l Route Number,
pital	eral (29a, Certifier 1 Certifyin	- Dhualalau Tuth	- 14 -6 1				· · · · · · · ·				
Hos 24 hg	Fun	Medical	(Check only one)	g Physician: To th Examiner: On the	basis of exam	ination and/or in	vestigation, in m	e time, dai iy opinion,	te and place, , death occuri	and due to the red at the time,	cause(s) a date and p	lace, and due to	tated. the cause(s)
The part of the pa						ber		29d. Date s	signed (Month,	Day, Year)			
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	<u>/1</u>		30 Name and address of parties	who completed cau	the of docth "	tem 22a) /T-mc	Print)	20	200		AALAA	7 7	21/21/11
	8		30. Name and address of person	WIND COMPleted Cau	Se or death (II	1/20a) (Type,)	Dalle Di	Aus.	110. A	Paulswis	5/ pli	Mar Dila	manlage
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sig	nature	FTIC	111	YEVL !		100	700000143	1 11/14/10)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 4:26 AM May **Physician** Polowy Erwetowski Suzanne 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours Min 1 M 2 X F 51 <u>1</u>956 June 23, Director 486-66-7447 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 1 ☐ Yes 2 No Anne Arundel Odenton Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** #103 21113 2605 Clarion Ct, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 XNo Specify. Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced ģ 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Security College (1-4or 5+) Elementary/Secondary (0-12) Directorate and Chief Agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Joanne Young ٥ Henry Polowy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Odenton, Maryland 21113 2605 Clarion Court, #103 <u>Jeffrey H. Erwetowski/son</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of I Important: If its any Injury or o 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crematory 5/10/2008 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licenses 1411 Annapolis Road Odenton, Maryland 21113 Homas Ucinta 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final Sepsis

Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Cellulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Examiner The law requires that the death certificate be executed diabetes attending physician and for use as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant Year 3 Ectopic pregnancy Month Day 1 ☐Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the aid be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy has performed? 2 No 1 Yes 2☐No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the h 29c. License number 29b. Signature and title of certifier 58510 person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway 30. Name and address of Annapolis, Maryland 21401 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Per FH G879 5/14/98 rtlllcate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Sr. Emva **Physician** Evina Pierre APRIL 2008 3:45 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BAZTIMORE HOSPITAL OF BALTIMORE (If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 02/10/1965 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1₩ M 2□ F Cameroon, W.A. 43 Director 692-01-0161 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1X Yes 2 No Balto Gwynn Oak Directo MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3402 Aurora Lane Apt. M 21207 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 4 yrs Telecommunications Engineer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Obama Francis Marie C. Evina P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra 3402 Aurora Lane Apt.M, Gwynn Oak, MD Marie С. Evina/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State June 1,2008 Yaounde, Cameroon 4 □ Donation 5 □ Other (Specify) Family Cemetery 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy St. NW, Washington, DC 20011 23a. Par 1. Enter the disease, or contribution, that clused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRA HEMORRHAGE **Physician** HOUR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ②★ No 24a. Was an autopsy performed? Yes 2,⊠No 1□ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Anatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bryand MD D0065563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINA HOSPITAL OF BALTIMORE RRYANT MORRISON -32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 MAY 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Fleishman 2008 8:10P Sophia 09 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 □ M 2 💢 F Netherlands 02.05.1931 Director 218.23.4112 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the first first institut to rotified at 1 Yes 2 □ No Baltimore Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21210 1123 Bellemore Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ho
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Piano Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 David Abraham <u>Johanna Bakker</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 21210 1123 Bellemore Rd., Baltimore, MDAvrom Fleishman/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 05.12.08 Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee M01442 P.A. 8717 Green Pastures Dr. Balto., Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA due to weeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 3 🗆 Ectopic pregnancy Month Ye ar Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe Yes 2 this certificate 1 □Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P the funeral 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

00 7 be executed Box 68760, o. Records, of Vital Division Hospital or Attending death.

Baltimore, Maryland 21215-0036

State

Registrar

29b. Signature and title of certifie

555W. Towsentown

eath (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

and manner stated.

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician 856 PM MAY 11 DONALD FRANKLIN 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOR SARNIT AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F Director 9-10-1955 <u>220-64-9147</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1438 CLAIRIDGE ROAD 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ▼ Never Married 2 Married 2 No 1 ☐ Yes 21 No Specify. Specify: Completed by 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LETTER CARRIER US POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AILEEN HUBBARD JAMES A. FRANKLIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHONDA ADAMS/FIANCEE 1438 CLAIRIDGE RD. BALTIMORE, MARYLAND item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5-17-2008 BALTIMORE, MARYLAND ARBUTUS MEM. PK. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRUCTIVE Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) CAMCER Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🔭 < nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed' 2/200 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the at d be detached fo Records, P.O. or Vital Physician: Division or Attending after death

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

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Health a

Baltimore, Maryland 21215-0036

29b. Signature and title of certifie

29c. License number 2161 29d. Date signed (Month, Day, Year)

, BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 OFOSU CATOM

and manner stated.

State Registrar 31. Date filed (Month, Day, Year)



within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N)a Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Security Number 7. Age (In yrs 8. Date of Birth (Month, Day, Year) Months 28-6000 1 2 M 2 □ F En. 12 Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No mde 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) ruck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 150× mes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto Friend 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature Funeral Service Lio 22. Name and Address of Famility 21229 march 23a. Part 1. Ft., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or

Director

Funeral

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Completed

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traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

and Mental Hygiene.

Department of Health an Important: If item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

sician and burial-tran attending physiclan for use as the buria ed by the s certificate has be irector, page 2 s

Physician/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the ft.

> State 'Registrar

DHMH 17 Rev 1/2001

ed D	oliesity, Co	JA, HTN			1 ☐ Yes 2[No 3□ Probably 4□ Unknown
Complet			ı		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
ě	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
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ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
Sertifica	3 Suicide 6 Could not be determined		nome, farm, street, factorify)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,
dical (hysician: To the best of my kr miner: On the basis of examir and manner stated.				and manner as stated. place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 05-09-2008

29b. Signature, and title of certifier

Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 2. Date of Death 1. Decedent's Name (First Middle Last) 3. Time of Death Physician Richard Α. Fry A^{M} May 5. 2008 7:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Manor Care Chevy Chase Montgomery 8. Date of Birth (Month, Day, Yea Sept. 25, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 X M 2 □ F 171-28-1899 73 Director PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if at Medical Examinat. Thust be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 TYes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 4545 Connecticut Avenue NW 20008 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Court Recorder US Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Elmer A. Fry Sara C. Frownfelter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Sherman Valley Rd., Elliottsburg, PA 17024 Helen Lyons (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Bloomfield Cemetery 5-10-2008 4 □ Donation New Bloomfield, PA 22. Name and Address of Facility
Boyer Funeral Home 21. Signature of Funeral Service Licensee 101 W. Main Street, New Bloomfield, PA 17068 Muni 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiorgan failure Year /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy Year Sequentially list conditions, if any leading to him reduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine sician and burial-trans Year Cerebrovascular accident Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760, Records, Division of Vital filled in by the completely

> State Registrar

29a. Certifie

(Check only one)

29b. Signature and title of certifier

Raman Tuli,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MD

MAY 1 4 2008

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10810 Darnestown Rd., Ste 202, Gaithersburg, MD

29d. Date signed (Month, Day, Year)

5-5-08

	Physici /Medic Examin	an al
1		Ç.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show a build many injury or other traumatic event, the Medical Exeminer must be notified at one.	To Be Completed by Funeral Director
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Division or Vital Records, P.O. Box 6876

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or after Dire	Certification:	4 Homicide	determ	illed	build	ding, etc. (8	Specify)						City or To	own, Sta	ite)			
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tos 4 ho Fun ely f	ca	29a. Certifier (Check only	2 Medical	Examine	er: On the	basis of ex-	aminatio	on and/or	investigation	at the til , in my d	me, date a opinion, de	ina piace, eath occur	and due to the	e cause e, date a	(s) and mai ind place, a	nner as and due	s stated. to the caus	e(s)
To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh	Medical	one)			and ma	nner stated	l											
To To	2	29b. Signature and	title of certifie	er					29	c. Licens	e number				_		h, Day, Year	
		1/1	Vari	· intl	1-11	um	22/			1) (17.	-10		M	AV	114	200	F
1	ŀ	30. Name and add	ress of nerson	who com	nleted car	ise of death	n (Item ?	23a) /Tvn	e Print\		1-3	, 0		. /	-//		-,00	U
ا حا		M. 1/A	SANT					1	51	1. 1	V D.	. ,	011	2		MI	1217	2 >
1		31. Date filed (Mg/		11.71				ire ire	200	U i	4.10	LLI	NG 1	COA	D,	. L	- 11	0
Sta Registr		or. Date filed (MO	MAY 14	2008	S Just	Registrar's	10	No. of the same of	media									

Registrar

			State Amend 20b-c, perFH, 8879 5/23/08 T	id / Depa <i>Cer</i>	rtment of F	Health <i>Death</i>	and Me	ntal Hy	giene Reg. No.	2008	3 15750		
	- 3		Decedent's Name (First, Middle, Last)					Date of De	ath	Vans	3. Time of Death		
15.00	Physicia /Medic		Doris Gray					Month	9 Day	2.008	18:05 M		
	Examin		4a. Facility Name (If not institution, give street and number)	10	4b. City, Town, o	or Location	of Death		4c. C	County of Deat	th		
	A Property of the Control of the Con	- 10	University of Maryland Media		If Under 1 Year		124 Hrs. 18	Data of Bird	h	O Die	Abalasa (Chata ay Faralas		
и	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 1 \(\text{ M = 1} \) \(\text{ M = 1} \) \(\text{ Sex 1 \(\text{ M = 2} \) \(\text{ F 1 \(\text{ M = 2} \) \(\text{ M = 1}	Yrs.	Months Days		Min.	Date of Birt (Month, Da	y, Year)	Co	thplace (State or Foreign ountry)		
ile.	Director		214-56-8439				<u> </u>	2 01	50)	MD		
	yland now at		10a. State 10b. County 10c. Cit	ty, Town or Loc	eation						10d. Inside City Limits		
	a-f st	ctor	MD NA I	Baltim				1 XYes 2 ☐ No					
	or 28	Director	10e. Street and Number		10f. Zip Code				10g. Citize	en of What Co	ountry?		
	ath w		3407 Elgin Ave			216				U.S.A			
	er de items	Funeral	11. Marital Status 12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Or oan, Mexica	rigin? (Specif an, Puerto Ric	y Yes or No can, etc.)	- 1	 Race - Ame Black, Whit 			
36	rs aft I", or xami	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, ♣☐ No If Yes, Give 1	1	☐ Yes 2X No	Specify	' :			Specify: Black			
9	filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	pel	15. Decedent's Education	16a. Deced	ent's Usual Occu	pation			16b. Kin	b. Kind of Business/Industry			
75	hin 72 an "na Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	(Give kind of work done during most of working life. DO NOT use retired)					7			
2	ed wit		12th grade 5yrs+	Tech	inical	_					Martin		
p	be file tal Hy d oth event	Be (17. Father's Name (First, Middle, Last)			18. Moth	ier's Name (F	First, Middle,	Maiden S	Surname)			
ya	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	1	Silas James Mack				ia Co						
Maryland 21215-0036	ges 1 and 2 should the freath and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print)		g Address (Street				-				
6,	es 1 and 2 of Health I item 27 i r other tra		Donita Dennis-Daughter 20a. Method of Disposition 20b. 1		Sandal v	wood	Road	-		MO ∠⊥ ation - City or			
Baltimore,	Pages nent of H ant: If ite		Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	natory or other pla					el. MD	Town, State		
				ng Men	orial	Park	5/16	/08	·WOO	dlawn	Md-		
Ba	permit. Depart Import any Inj once.		21. Signature of Pulleral Service Littersee	Ma	Name and Addr rch F/I	H Wes	s't	Bal+i	more	e, Md	21215		
			23a. Part1. Enter the dispase, or complications that caused the deat							e, Ma	Approximate		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
,	/Medical		immediate cause (inal disease or condition resulting in death) a. MetaHatic AdunoCarcinana of the Lung Due to (or as a consequence of):										
	Examiner			1401100 017.									
	1 25 A	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus. Cliscas of fight.	uence of):									
	ransit	Examiner	that initiated events										
Ö,	ate be executed hysician and the burial-transit	EX	resulting in death) Last Due to (or as a consec	quence of):									
8760	ificate be executed in the physician and its the burial-transit	dical	d										
φ ×	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as the control of the control	Physician/Med	IF FEMALE:										
Box	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	al death 3 □Ectopic pregnancy						23d. Date of delivery Month Day Year			
	the de	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of 0 9 ☐ Unknown 9 ☐ Unknown	jeatri 5∟	Other (specify) _								
о. О.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not res	sulting in the un	iderlying cause gi	ven in Part	I.	23e. Did t	obacco us	e contribute to	o the cause of death?		
g	uires I sign Id be	d by						10,	Yes 2□]No 3□P	robably 4 dnknown		
Ö	w req	lete						24a. Was	an	24h. Were ai	utopsy findings available		
Vital Records,	he lav e has age 2 :	Completed						autor perfo	rmed?	prior to death?	completion of cause of		
ta			25. Was case referred to medical			26. Plac	e of Death (1□ Yes Check only o		1 □ Yes	2 No		
	ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	t 3□ DOA Oti	hor:				□Other (Spe	ecify)		
Division or	rding Phys h. After this funeral dir		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred										
0	endir ath. or: Af	atio	2 Accident investigation M 1 Yes 2 No										
Š	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Floute Number, City or Town, State)										
	ital or ral D ral D led ir												
	Hosp 4 hou Fune Tely fi	ical	29a. Certifier 1 ✓ Certifying Physician: To the best of my know (Check only 2 ✓ Medical Examiner: On the basis of examination of the basis of the basis of examination of the basis of the basis of the basis of the basis of examination of the basis of	owledge, death ation and/or inv	occurred at the trest estigation, in my	time, date a opinion, de	and place, and eath occurred	d due to the at the time,	cause(s) a date and	and manner as place, and due	s stated. e to the cause(s)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	se number			29d Date	signed (Moni	th. Dav. Year)		
	S 7 ₹ 7	_		4 -			. (9/2005			
7	1		30. Name and address of person who completed cause of death (Iter		-	222	7		>/	71 200	<u> </u>		
	り		Minghan Les Tsay 22. South	Green		£	3alt7ma	7 MA	2129	i c			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signal		2540	P	CTVN'G	U, 1711	LI LI				
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Mary Jo Geigan PM 10 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sauare timore tranklin spita Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign
 Country)
 TaTT7 **Funeral** 1 □ M 2 □ KF Months Days Hours Min. March 24, 1938 216-34-3768 70 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be refined at Baltimore Middle River MD Director 1 ☐ Yes 2X No 10f. Zip Code 21220 10e. Street and Number 10g. Citizen of What Country? USA 2234 Redthorne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □Yes 2 If Yes, Give 1 Never Married 2 Married 2X No Saltimore, Maryland 21215-0036 "natural", or i 1 □Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnetic poince. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew B. Collins Genevieve V. Bennett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Pine Creek Court Abingdon MD 21009 Edward L. Geigan /son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/08 MD Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD alve Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Failure **Physician** Henau 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Insufficienc Sequentially list conditions Examine If any, leading to inflied ate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Pregnant at time of death 5 Other (specify) o the detached 9 Unknown 9 Unknown σ. signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 X Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deat Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Property of the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the within 7 29b. Signature and ertifie 29c. License number 29d. Date signed (Month, Day, Year) D006476 VASILIAOT, M.S

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

9000 Franklin Square Dr. Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

linus

31. Date filed (Month, Day,

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

	4	For State Registrar			partment of H e <i>rtificate of L</i>			g. No. 2 () ()	8 15752				
		1. Decedent's Name (First, Middle,	/ 1				2. Date of Deat Month	n Day Year	3. Time of Death				
siciar edica		SHIRLEY,	GRINNI	AN			5	12 08					
mine	-	4a. Facility Name (If not institution,	give street and number)	250/201	4b. City, Town, or	Location of Deatl	1	4c. County of Dec					
- 10 miles		GOOD SAM,) (1 7 7	SPITAL	BAL	If Under 24 Hrs.	lo But of Blade		THORE (IT)				
al or		5. Social Security Number 212–34–9432	5. Sex 7. Age 1	(In yrs. last birthda 7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	(Month, Day, Year) March 20, 1931 Virginia					
ar is	-	Usual Residence of Decedent					March 20	J, 1931 VI	Igilia				
١.	. [10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits				
	Director	Maryland		Baltimor	3				1 X Yes 2 No				
1		10e. Street and Number			10f. Zip Code		1	Country?					
		5311 St. George			21212			U.S.A.					
	runeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		 Was Decedent of His If Yes, specify Cuba 	spanic Origin? (S ın, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh					
	by F.	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	Black				
		15. Decedent's	Education		edent's Usual Occup			16b. Kind of Busines					
	ble	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	`life	ve kind of work done o DO NOT use retired	turing most of woi !)	rking						
	Сотрыетеа	4			aborer			Electrical					
1	To Be C	17. Father's Name (First, Middle, La	ast)			18. Mother's Name (First, Middle, Maiden Surname)							
		Willie Grinnan					a Lacks						
ı		19a. Informant's Name/Relationship		l	iling Address (Street a								
ŀ		Sadie Sturdivan 20a. Method of Disposition	t (Sister)	20b. Place of Dis	St. Geor	;		20c. Location - City of					
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State											
	-	4 Donation 5 Dother (Special Service Li		Lacks F				JIOVEL, VA	<u> </u>				
		1	2/1/		22 Name and Addres Jeffress 2000 N M	Funeral	Home South Bo	oston, VA	24592				
Ė		23a. Part1. Enter the disease, or c	complications that caused the	he death. Do not e					Approximate Interval Between				
ŀ	1	shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line		·alami	L'-0 1	una di	00-00	Onset and Death				
	ŀ	disease or condition resulting in death)	26936	years									
		Etiology unknown											
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):									
	xamıner	Cause (Disease or injury that initiated events resulting in death) Last											
Ú		resulting in death) Last	Due to (or as a	consequence of):									
1	Physician/imedical		d										
/M.B.	/Me	IF FEMALE:	23c. If yes, outcome pr	f pregnancy				23d. Date of d	olivon				
1	Clar	23b. Was decedent pregnant in the past 12 months? 4□Pregnant at time of death 5□Other (specify)							Day Year				
1	lysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown										
	y r	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death											
3	<u>α</u>	(1979es) 2 No 3 Pro											
	Completed	Chronic	Kidney	ease		24a. Was a		. Were autopsy findings available					
	<u> </u>	Dishetes	0				autops perfori 1∐ Yes	ned2 death	prior to completion of cause of death? 1 □ Yes (2 X No)				
	e le	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on						
		1 Yes 2 No	Hospital: 1 1 Impatient			4 Li Nursing r	Home 5 Reside	ence 6 □Other (Sp	pecify)				
	cation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		/ Worl		28d. Describe ho	w injury occurred					
		2 ☐ Accident investiga	ntion I	I	M 1 🗆	Yes 2 ☐ No	1						

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier

3 Suicide

4 Homicide

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Res. 000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NABIL ZEINEH, GOOD SAMARITAN HOSPITAL, S601 LoCH RAVEN BLVD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State

Certifica

Medical

and manner stated



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician 8-30 AM ROSEMARY GAFFNEY 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) **Funeral** Months Hours Days 1 □ M 2 🛛 F 64 Director Apr. 13, 1944 191-34-3150 Nevada Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ☐Yes 2X No must be notified Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

int: If Item 27 is marked other than "natural", or items 23a o 21014 USA Funeral 722 Highplain Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist U.S. Government Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Joseph Gaffney, Jr. Doris Rita Funk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau Margaret Gaffney - Sister Orchard Street, North Dartmouth, MA 02747 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/16/08 Darlington, MD Darlington Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Ent fr the disease, or complications that course the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LIVER METASTASES 6 MONTHS /Medical Due to (or as a consequence of): Examiner 2 YEARS CANCER IR REAST Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ENCEPHALOPATIFY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MEPATIC Completed PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 240 or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 No ^oL 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division (Month, Day Year) 1 Natural Injury 5 ☐ Pending 1 ∏Yes 2 ∏No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D021207

State Registrar

31. Date filed (Month, Day, Year) MAY 1 4 2008

C



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VELLA - CAMILLERI

5 MIDCREST CT., BALTIMORE

DHMH 17 Rev 1/2001

,000 21286

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. REPLACEMEN State of Maryland? Department of Health and Mental Hygiene Reg. No. 2008 15754 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 12 1:00 p^M JACQUELINE MARIE HICKLING MAY 2008 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 319 S. STRICKER STREET BALTIMORE CITY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) ST ANN JAMAICA 8. Date of Birth (Month, Day, Year, **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 053-54-0574 44 Director 11/10/1963 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at XXYes 2□No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STRICKER 21223 319 S. USA Funeral STREET 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status unknown Armed Forces? 1 □Yes 24 No 72 hours after 1 ∐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1∐Yes 2∭Wo Specify. ₽ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wiي. عا Hygiene. ع**r than "**ت (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) CAREGIVER (CNA-LICENSE) HEALTH CARE and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be d 2 should be fi th and Mental I STANLEY HICKLING traumatic ျှ ELUA CLARK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra SHAMMA J. HICKLING-STRICKER STREET, SON 319 S. BALTIMORE, MD 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO 5/14/08 4 Donation 5-☐Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

↑ E Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Certification 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death

Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hou.. the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanoven St. ECHO MP A 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 6 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 2008 **Physician** May 12, Roy E. Hill 12:55 P^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Genesis Health Care Severna Park Anne Arundel Severna Park 8. Date of Birth (Month, Day, Ye June 18, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year. Hours Months 1 🕱 M 2 🗆 F 77 1930 Maryland 212-26-2660 Director Usual Residence of Decedent 10d. Inside City Limits iled within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedgal Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Marvland | Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 119 Wilson Blvd. 21061 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 ₩Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Paving Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked o George Hill Pearl Mae Rimsburg မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Cynthia K. Ridenbaugh/Daughter 209 Margate Drive, Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition May 15, 2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn Park, Maryland Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, a. MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Exami and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) □Yes 2□No P.0. 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No certificate 2 🗆 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4

Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ funeral 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 □Yes 2 □ No the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prote Drive Clarke, MS 21619 76-1 32 Registrar's Signature Date filed (Month, Day, Year) State 2008 14 'Registrar

08-03562 David Henderson

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2008 | 5756

2112 11011201001		- For State Certificate of Death Reg. No.
Physicia	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 2.127 hrs
ledical Examin		David Henderson Way 9, 2008
		Johns Hopkins Hospital Baltimore
Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. 9-22-1989 Foreign Country) MD
daryland 28a-f show any d.at.once.		Usual Residence of Decedent 10a. State
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2025 E. 31st Street 21218 U S A
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examingr must be notified at once	— ∟	11. Marriad Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
hours after natural", c	⋧┞	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
21215-0036 Juld be filed within 72 I Mental Hygiene. marked other than ",	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade N/A Disabled 17. Father's Name (First, Middle, Last) Disabled 18. Mother's Name (First, Middle, Maiden Surname)
21215-00 uld be filed wit Mental Hygien marked other	ပ၂	John S. Henderson Geneva Chaney
2121! hould be fil nd Mental Is is marked aftic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, MD I and 2 sho Health and item 27 is		Geneva Jobes-Mother 2025 E. 31st Balto, MD 21218 202 Method of Disposition (Name of cemetery. Date 120c. Location - City or Town, State
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 X Burial 2 Cremation 3 Removal from State King Memorial Pk Other Specify: Crematory or other place) King Memorial Pk 5-16-08 Randallstown, MD
Balt Sermit. Departi Import		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Medical Fxaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
	iner	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Course
60, e be executed ysician and burial - transit	I Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
60, e be exe ysician 8	Medical	UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)
P.O. Bc		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ords, P.C. w requires that is been signed should be det	ted by	1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
ecor he law rate has b age 2 sho	Completed	autopsy prior to completion of cause of performed? death? 1 Ves 2 No 1 Ves 2 No
tal Rec	Be C	25. Was case referred to medical 26.Place of Death (Check only one)
Vita hysici this o		examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other:
ion of tending Ph. eath. tor: After the funeral		27. Manner of Death 1 Natural 5 Pending Natural 5 Pending May 9, 2008 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 No Subject shot
Division of Vital Records, pital or Attending Physician: The law require ours after death. eral Director: After this certificate has been sifiled in by the funeral director, page 2 should the control of the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 W Homicide May 9, 2008 2140 hrs 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f0 Hillen Road, Baltimore, Md.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
T wi	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Carde Hallan O.C.M.E. May 10, 2008
$-\gamma$		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Regist	rar	MAY 1 4 2008 Beasures D. James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1.0.0)

			For State Registrar	Ce	rtificate of Death		g. No.	10/0/			
	Physicia	an	Decedent's Name (First, Middle, Last) Richard Hudson			2. Date of Death Month May 10	Day Year	3. Time of Death 7:29p M			
	/Medic Examin		4a. Facility Name (If not institution, give street Carroll Hospice Dov		4b. City, Town, or Location of Death Westminster		4c. County of Death				
0	Funeral Director	Ĭ	5. Social Security Number 6. Sex 157 M	2□ F 7. Age (In yrs. last birthday, 53 Yrs.		8. Date of Birth (Month, Day, Sept 28	9. Birth	nplace (State or Foreign untry)			
	Maryland f show led at	tor	Usual Residence of Decedent 10a. State	10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 🏋 No			
	h with the l 3a or 28a- st be notif	Funeral Director	10e. Street and Number 14275 Old Frederick	Road	10f. Zip Code 21723		g. Citizen of What Coi JSA	untry?			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 → Never Married 2 → Married	Was Decedent Ever in U.S. Armed Forces? 13. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: whi	e, etc.			
21215-0036	I within 72 ho jene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade continuous Elementary/Secondary (0-12)	mpleted) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) vator mechanic	king i	6b. Kind of Business/l elevator	Industry			
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Richard Hudson	,		ne <i>(First, Middle, M</i> Adamski	aiden Surname)				
	and 2 sho ealth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Mary Hudson (mother) 1388	ing Address (Street and Number or Rull Forsythe Rd., S	ykesville	, MD 21784				
altimore,	Pages 1 Iment of He tant: If Iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	Crest La	wn Memorial 5-16	-08 M	oc. Location - City or arriottsvi	11e, MD			
Ball	Depart Import any in		21. Signature of Funeral Service Licenset	eight "	22. Name and Address of FacilityHad P.O. Box 195 Sykes	ght Funer sville, M	ral Home & D 21784	Chapel			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SMALL CFLL CARCINOMA OF LUNG Due to (or as a consequence of):								
	Examiner	лег	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	ESIONS-CERVICAL			9 MONTHS			
68760,	rtificate be executed ng physician and as the burial-transit	ical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	TETASTATIC LES Due to (or as a consequence of):	sions- ADRENA	_ GLAN	MD 21784 Try arrest, Approximate Interval Between Onset and Death APPROXIMATE INTERVAL PRINTER INTERVAL P				
O. Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year			
Δ.	w requires that been signed by should be deta	by	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I.	23e. Did tob 1 ☑ Ye	acco use contribute to	o the cause of death?			
al Records,		Completed				24a. Was an autopsy perform 1∐ Yes 2	/ / prior to d	utopsy findings available completion of cause of 2 No			
or Vit	hysiciar this certif al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	1 Inpatient 2 EH/Outpatie	ent 3 DOA Other: 4 Nursing H		nce 6 Other (Spe	city) HOSPICE			
Division or Vital	Attending Physician: r death. ector: After this certifics by the funeral director. p	Certification:	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho					
DIV	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		4 ☐ Homicide determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town					
	the Hos in 24 ho the Fun ipletely i	Medical	(Check only 2 Medical Examiner one)	: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, da	ate and place, and due	e to the cause(s)			
)	with con	2	29b. Signature and itle of certifier	レシ	29c. License number D16206 Print) ELDERSBURG, M	29	5/12 (20	in, Day, Year)			
4	? Y		30. Name and address of person who comp EPALLAN, N.D. 1380	PROGRESS WAY	Print) ELDERSBURG, M	D21784	(CARROLL	PRIMARY CARE			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	South &						

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		•	1 - State Registrar	, , , , , , , , , , ,	Ce	ertificate of	Death		Reg. No.	08	15/58
ı	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month	ath Day	Year	3. Time of Death
6.3	/Medic	al	Albert M. H 4a. Facility Name (If not institution, give	icks, Jr.		4h City Town o	r Location of Death	May 1	0 2008 4c. County		
	Examin	er	Carroll Hospice			Westmin				ro11	
	Funeral Director		5. Social Security Number 6. Sunknown	ex 7. Age (In yrs. I. X	ast birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthp Coul MD	
ī	pur w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or	Location	· · · · · · · · · · · · · · · · · · ·				10d. Inside City Limits
	Manyla f sho	tor	MD Carroll		ykesv						1 □ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Number 6655 Sykesville	Road		10f. Zip Code 2178	34		10g. Citizen of W	Vhat Cou	ntry?
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13	B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.)	- 14. Race Black	e - Americk, White,	can Indian, , etc.
215-0036	ours afte ral", or it Exa <u>min</u>	by	1 🛣 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 ∏No If Yes, Give X Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify	whi	.te
בה	n 72 h "natu edical	letec	15. Decedent's Ed (Specify only highest gra	ide completed)	16a. Dec	edent's Usual Occup ve kind of work done . DO NOT use retire	oation during most of worl d)	king	16b. Kind of Bu	siness/In	ıdustry
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מפ	be filectal Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surnam	10)	
yiand	d Men narke	၉	Albert M. Hicks		10b Ma	iling Address (Street		n King	or City or Town	State 7i	in Codol
Mar	nd 2 st lith and 27 is r r traur		Springfield Medica			Sykesvi1			-	-	
e,	es 1 au of Hea fitem rothe	3	20a. Method of Disposition	20b. P		position (Name of rematory or other pla		Date	20c. Location -		
saltimore,	. Pag tment tant: It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y) A1:	1 Cou	nty Cremat	ion 5-13	-088	Sykesvil	le	MD
Rai	permit Depar impor any In		21. Signature of Funeral Service Licen Paray Hargurt			22. Name and Addre					Chapel
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not e		1	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cirrhos		CHepat	(2)			_	
	Examiner			Due to (or as a consequ	ience or):						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Liner funding Cause (Disease or injury	Due to (or as a consequ	ence of):					1	
	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):						
98/60	e be e /sician e buris			d							
200	rtificat ng phy	Medical	IF FEMALE:								
). B0	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	B□Ectopic pregnanc B□ Other (specify) _	у			te of deliv onth	very Day Year
л О	that the		Part II. Other significant conditions of	contributing to death but not resu	ilting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use conti	ribute to	the cause of death?
rds	w requires that the de been signed by the s should be detached	ed by	Hepatity C	Schizo aff	echu	& Disore	les	1 🗆	Yes 2 No	3 ☐ Pro	obably 4 ∐Unknown
Vital Records,	e law re has bee e 2 sho	Completed						24a. Was	osy j		topsy findings available ompletion of cause of
E E	ician: The lav certificate has ector, page 2	e Co	25. Was case referred to medical				26. Place of Dea	1☐ Yes	2/2(No 1	1 ☐ Yes	2 No
	Physician: r this certific ral director,	O B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpat	ient 3 DOA Otr	ner		dence 6 Oth	er (Spec	:ify)
ion or	Ing After une	ation: 1	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injun	/ Wo	ry at rk? Yes 2 □ No	28d. Describe	how injury occurr	red	
Division	To the Hospital or Attending Physician: within 24 hours affect death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm,	street, factory, office		28f. Location (City or To		er or Rui	ral Route Number,
	To the Hospit within 24 hours To the Funers completely fille	edical (29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my kno- miner: On the basis of examina and manner stated.	wledge, de tion and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
^	T		Datah due	De De	00e\ (T		3939		5/12		
1	0	5 1	30. Name and address of person who Babak Ima nor	, Do; 218 Wa	shins,	In Heights	Med Ctr	; westn	wkr, M	D	21157
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 4 20	3. Registrar's Signa	ture	and i					

			For State Registrar	State of Marylar			of Health and I of Death		ene∠ U U g. No.	0 13/39
	Dhysiai		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic	_	Dennis Hewitt					May 1,	2008	9:34 AM M
	Examin	er	4a. Facility Name (If not institution, give s			•	wn, or Location of Death	1	4c. County of D	
			417 Joppa Farm Ros 5. Social Security Number 6. Sex		last hirthday)	If Under 1 Y	ppatown Year If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director		218.46.2491	¥ 2□ F 61	Yrs.		Pays Hours Min.	03.18.1	Year)	Country) MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -f ehc	ţ	MD Harfor	d 1	орра					1 🗆 Yes 2,250
	r 28a	Irec	10e. Street and Number	<u>u</u> 1 0	орра	10f. Zip Co		10	g. Citizen of What	Country?
	th with	alD	417 Joppa Farm 1	Road		21	085		U.S.A.	
036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f ehow aumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Devivorced	2. Was Decedent Ever in U Armed Forces? 1 Syes 2 No If Yes, Give Year or Dates		Vas Deceden f Yes, specify I ☐ Yes 2	t of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc. White
21215-0036	in 72 ho n "natur de dicul	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ient's Usual C kind of work o DO NOT use i	done during most of wor	rking	6b. Kind of Busine	ess/Industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Mec	hanic			Automot	ive
Maryland	oe filed al Hygi d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M	faiden Sumame)	
<u>X</u>	should be ind Mental I marked o	၉	Hartzell Hewit					ntoinet		
Mag			19a. Informant's Name/Relationship (Type				treet and Number or Ru			e, Zip Code)
	1 and Health em 27		Lori Hewitt/Ex-	20b.	Place of Dispo	sition (Name	of	ppa, MD	21003 Oc. Location - City	or Town, State
<u></u>	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State Ch	cemetery, crer lesape	ake C	rem. 05.	12.08 B	eltsvil	le, MD
Baltimore,	permit. Pages Depertment of Important: If it eny injury or o		21. Signatore of Funeral Service License	Ration						Lohrmann, Balto., MD
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the dea						Approximate Interval Between
2	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	6.1	volal	Infan	rction			Onset and Death
	Examiner		Sequentially list conditions	Corona	ry A	tery	Disease			>7years
	D it	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	l				,
1	xecute and N-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence ol):					
387605	icate be executed physicien and the burial-transit	dical								
_		•								
O. Box	The law requires that the death certifis tte ⊩as be⊧n signed by the ettending t bag⊭ 2 shculd be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregi Other (speci			23d. Date of Month	delivery Day Year
P.0	res that the igned by be detact	y Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying caus	se given in Part I.	23e. Did tob	acco use contribut	te to the cause of death?
g	puires n sign uld be	d by						1 5 ₹ Ye	s 2□No 3□	Probably 4 Unknown
S	aw requires is been si	Completed						24a. Was ar	24b. Wer	e autopsy lindings available to completion of cause of
Ĭ		E						perform	ned? deat	h? Yes 2 No
/ita	ysiclan: The list certificate le	Be	25. Was case referred to medical examiner?					ath Check only one)	
5	Physician: r this certification, ral director, i	မ	10 165 20110		ER/Outpatier			lome 5 Aeside		Specify)
lon	Attending For death. ector: After by the funeral	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 280	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
Division of Vital Records,	Hospital or Attended to the control of the control	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, lactory, o	ffice	28f. Location (Sti City or Town		r Rural Route Number,
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kner: On the basis of examinand manner stated.	owledge, death ation and/or in	n occurred at vestigation, in	the time, date and place my opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manne ite and place, and	or as stated. due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	0		29c. L	icense number	25	9d. Date signed (M	fonth, Day, Year)
	1/1		Salanda	lens		Do	0035363		5/7/08	
	かれい		30. Name and address of person who co	mpteted cause of death (Ite	om 23a) (Type,	Print) Stre	ect Bulton	me MD S	21201	
	Sta		31. Date filed (Month, Day, Year) 4	32. Redistrar's Sign	nature	Society !	- Elmin	7		
1	Registr	ar	mui T 3 c	A PROPERTY.	No. 1	1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.Z. UU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month LINDA HASKETT 22:50 PM May 2008 12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-26-1948 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 F 218-46-9810 59 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 PENNSYLVANIA AVENUE APT. 1A 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🛣 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **JOURNEYMAN** BALTIMORE SUN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES BYRD MARY LEE WARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) QUINTON ANDERSON/SON GEMMA RD BALTIMORE, MARYLAND 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State PARKWOOD CEMETERY 5-17-2008 4 Donation 5 Dother (Specify) BALTIMORE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses forton ames 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 23a. Parti /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia 3 days Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End-stage renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

the burial-transit

as

signed by the attending physician

has

this certificate

After

within 24 hours after death To the Funeral Director:

funeral

or Attending Physician:

the death certificate be executed

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Vital Records,

Division or

Examiner

Physician/Medical

Completed

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Certification:

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Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

10a. State

MD

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie filem 27 is marked other if other traumatic event, the

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

End - Stage liver disease

Anemia

1 Matural

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 🗹 Inpatient 27. Manner of Death

, MD

28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA

2 🗷 No 1☐ Yes

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24a. Was an

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

Fazeli

29c. License number OP19513

29d. Date signed (Month, Day, Year) May 12, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parastoo Fazeli, St. Agnes hospital, 900 S. Caton Ave. Baltimore, mo 21229

28b. Time of

State Registrar

31. Date filed (Month, Day, Year) MAY 14 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ale of Marylan		tificate o		viorita	Re	g. No.	008	15761
	∍ Physicia	an	1. Decedent's Name (First, Middle, Last)	*** 1.7				Mor		Day	2008	3. Time of Death
	/Medic	al	Phleet Grays		У	4b City Town	, or Location of Death	Mā	ıy	9,	2008 ounty of Death	22:15P ^M
	Examin	er	4a. Facility Name (If not institution, give street Upper Chesapeake Med			*	L Air			40.0	Harfo	ord
	Funeral Director		5. Social Security Number 6. Sex 1XI M	7. Age (In yrs.		If Under 1 Ye Months Day	ar If Under 24 Hrs.	(Mo	e of Birth nth, Day, . 18	Year) 19	Coul	place (State or Foreign ntry) ntana
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl -f sho fied a	tor	Maryland Harford	Bel	Air							1 ☐Yes 2 ☐No
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Cod	е		10	g. Citize	n of What Cou	ntry?
	ath will		914 Rockspring Road	1		2101		- 2 12		UŞA	I, Race - Ameri	een Indian
	er de: Items ner m	Funeral	A Partial Status	Vas Decedent Ever in U. ∧rmed Forces? ∐Yes 2 ★No	.S. 13. \	Was Decedent of f Yes, specify C	of Hispanic Origin? (S Suban, Mexican, Puert	o Rican, e	s or No- etc.)	14	Black, White,	
36	urs aft ul', or xami	by F		Yes, Give ear or Dates:		1□Yes 2√AN	No Specify:			S	Specify:	White
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	ted	15. Decedent's Educatio (Specify only highest grade con	n naleted)	16a. Deced	dent's Usual Oc	cupation ne during most of wor iired)	king	1	l6b. Kind	of Business/Ir	
21215-0036	vithin ne.	Completed		College (1-4or 5+)						D	:	
	be filed w ntal Hygie id other th event, th	S	17. Father's Name (First, Middle, Last)		House	e Painte	18. Mother's Nan	ne (First,	Middle, N		int Sto urname)	re
Maryland	ental ked o	To Be	Louis David Hartley	7			Callie	(nmn)	Hac	:h		
ary	2 should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Type. F		19b. Mailir	ng Address (Stre	eet and Number or Ru				Town, State, Zi	p Code)
	1 and 2 Health a tem 27 is		Dorothy Hartley / Wi				ing Road, 1					01-1-
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	vai from State		sition (Name of matory or other		Date			ation - City or T	
ij	rt. Par rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) 21. Signatur → Funer Service Licensee	Bel			Grdn 5-1.				Air, Ma	ryland
Ba	permit. Pages Department of Important: If I any Injury or one.		21. Signatur Puller Service Licensee	rads.			Funeral Ho Broadway S				MD 21	014
			23a. Parti. Enter the disease, or complication shock, or heart failure. List only one care	on that caused the deat	h. Do not ent	er the mode of	dying, such as cardiac	or respi	ratory arre	est,	_140 21	Approximate Interval Between
	Physician			Atheroscle	Rotic	Car	6.8.14504	la R	dis	eas.	e	Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	uence of):							
В	Examiner	L.	Sequentially list conditions, b	Sue to for as a consid	ssorno alla							
	Bi A tig	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240 to 101 de 4 0011000	partice on,							
Ć	execunary and ial-tra	Examiner	resulting in death) Last	Due to (or as a consec	uence of):							
68760,	ritificate be executed ing physician and seas the burial-transit	edical	d									
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Вох	w requires that the death cen been signed by the attendin should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	f yes, outcome pf pregn 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3	☐Ectopic pregna ☐ Other (specif)				23	3d. Date of deliving Month	very Day Year
P.O.	the de	nysic		9 Unknown			/					
	s that ned b e deta	by Pt	Part II. Other significant conditions contribu	uting to death but not res	sulting in the u	nderlying cause	given in Part I.	23				the cause of death?
Vital Records,	equire en sig ould b	edt							1 □ Y€	es 2] No 3 □ Pro	bably 4 Hunknown
ecc	28 28	Completed						24	la. Was ar autops perforr	y I	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
a H]Yes 2	2 PNo	1 ☐ Yes	2 No
Ζij		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hosp	ital: 1 ∏ Inpatient 2 ¶	ER/Outpatier	nt 3□ DOA	26. Place of De				☐Other (Spec	eifv)
0	ding Phys h. After this funeral di	n: To	27. Manner of Death 2	8a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	Т	escribe ho			,
ior	Attending r death. ector: After	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 day)	,,		1 ☐ Yes 2 ☐ No	<u> </u>				
Division	al or Attendii s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of injury - At h building, etc. (Speci	iome, farm, sti ify)	reet, factory, off	ice		cation (St ty or Town		l Number or Ru	ral Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical Co	29a. Certifier 1 ★ Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my kn On the basis of examin and manner stated.	owledge, deat ation and/or ir	th occurred at the	ne time, date and plac my opinion, death occ	e, and du urred at t	e to the c	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	ro the vithin of the comple	Mec	29b. Signature and title of certifier			29c. Lic	cense number		2	9d. Date	signed (Month	h, Day, Year)
	->-0		Malwh) ed 2)			d355	22		Ma	9 12,	2008
7	4		30. Name and address of person who complete MARK WILD	eted cause of death (Ite DO DO T 32. Registrar's Sign	m 23a) (Type,	Print)	DEI	1.0	,10	120	4, mile	1 21014
	St	ate	31. Date filed (Month, Day, Year) MAY 1 4 2008	32. Registrar's Sign	ature	ه فروس	1000	1111	Vec	1710	1 -MNC	
	Regist		MAY 1 4 2008	Alexander St.	1034							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician JACKSON 1817 2008 MAY WARDELL 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CITY HOSPITAL JOHNS HOPKINS BALTIMORE 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 8.27. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs 1 M M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 1207 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 2 🗌 No 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", or 3 ☐ Widowed 4 ☐ Divorced Year or Dates: permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical It once. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) First, Middle, 17_Father's Name (First, Middle, Last) Be Vid 16SON Baltimore, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 DAYS Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner 4. HOURS MENINGITIS Sequentially list conditions, if any, leading to immediate cause. Enter undership Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HERNIATION SELONDARY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HY?ERTENSION autopsy death? 1 □ Yes 2 □ No performed? 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☑ Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -000 2008. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Regis

32 Registrar's Signature

OD N WOLFE ST

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:50 PM FANNIE JACKSON MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mercy Medical Center Baltimore City Baltimore, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 214-40-3904 Months 1 ☐ M 2 💢 F 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 1 Yes 2 No ns 23a or 28a-f sh must be notified Daltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mang once. rivate duty 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bacto. -niece rud. aure, laylok 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 17-08 s downe 4 ☐ Donation ∕b ☐ Other (Specify) 22. Name and Address of Facility 21. Signature vi uneral Service Licent 21229 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease of the dise 23a. Party. Enter the essence, or heart failt Immediat ause (Final disease or condition resulting in death) **Physician** Pulmonary embolism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 3 ☐ Probably 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed/ es 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

; or items 23a

'natural",

than

To the Hospitai or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria this After within 24 hours after death

To the Funeral Director: ,
completely filled in by the f filled in by the

2 ☐ Accident 3 ☐ Suicide 4 Homicide

(Check only one)

29a. Certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) f certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

M.D. Neda Frayha

29c. License number

29d. Date signed (Month, Day, Year) May 11, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mercy Medical Center, 301 St. Paul Place, Ralhimore, MD 21202 Neda Frayha, M.D

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 1 4 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fb 8879 5-14-08 wt state of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** avis 4:34 PM 0.2008 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA HENES BALTI MOLE HOSPITAL 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 20, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 218-60-3514 1□M 2 Months Hours Days Min. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 √yes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Insted States Co 11/19 21205 Honus ton Funeral Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", any hjury or other traumatic event, the Medical Era any hjury or other traumatic event, the Medical Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home touse w 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Davis harles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto: MD 21205 Daughter Collington Watson North elma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltor MD 21229 May 16,208 21. Signature of Funeral Service Licensee 1. a (40, MO 21229 70 redhilton Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** temy 2000 01 disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** 000CY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transit and Due to (or as a consequence of): トラトンで Records, P.O. Box 68760, physician Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FFMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 nknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No After this certificate 2□ No 1 □ Yes Division or Vital Physician: uneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 20 5 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 2008 1 Registrar 4

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Somanton Baltmore 17 more Year | If Under 24 Hrs 8. Date of Birth (Month, Day) 9. Birthplace (State or Greign Country) 7. Age (In yrs. last birthday. 6. Sex 5. Social Security Number **Funeral** Months Hours Min. 1 □ M 2 🗹 F 12/01/1924 Maryland 83 Director 224-26-1052 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 21234 U.S.A. 3344 Woodside Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify Be Completed by Year or Dates: 3 X Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Lry or other traumatic event, the M Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Augusta Matthai Fred Lauer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9629 Tenth Avenue, Baltimore, MD 21234 Edward C. Kane, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 05/16/2008 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Road, Baltimore, MD 21214 Suprandus 5305 Harford 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Apua Paga sseminated Due to (or as a consequence of) burial-Box 68760. the attending physician hed for use as the burla Physician/Medical eymonia the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? res 2 No this certificate Division or Vital 25. Was case referred to medical examiner? director. 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
1 Natural
2 ☐ Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of uneral 28d. Describe how injury occurred After 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No death. To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DV. Rich and Park , 5601 Loch

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 14

2008

32. Rasstrar's Signature

Raven Blud, Boutmore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year ERALD 09 2008 ALLEN MAY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) SILVER SPRING MONTGOMORY 9000 DRIVS LOCKIZINAS If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 M 2 □ F 68 7523568 ILLINOIS Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No 4LV EVZ SPRING MONTHON ? 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20901 10709 DRI UE LOCKRIDIXE 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) us housement ATTORNET 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNETTE GEOIZGE LANG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SILURE SPRING MO 20901 LOCKINIBUE DRIVE MAIZION LANGE 500US6 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HAHOUR, MD ANATONY WETS THUSTRY 5/14 DOUB 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Poneral Service Licensee HANDUR, MS 7522 CONTIETES DICUS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer to Peritoneum years Due to (or as a consequence of): Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considuence of Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a4 show any highry or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician as the g after death.

Director: After this d in by the funeral d

or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner an/Medical

ıysıcı	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at time of death 5□ Other (specify) 9□Unknown	Month Day 10th
a by Pr	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
complete			24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
a)	25. Was case referred to medical	26. Place	of Death Check onl one
0	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu	rsing Home 5 Residence 6 Other (Specify)
ation:	27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident investigation		28d. Describe how injury occurred
Sering	3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my knowledge, death occurred at the time, date an iminer: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	d place, and due to the cause(s) and manner as stated. th occurred at the time, date and place, and due to the cause(s)

29c. License number

026250

29d. Date signed (Month, Day, Year)

LARGO.

05/12/2008

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24 hours a

within 2

		- 1	For State of Mai		artment of Health a rtificate of Death		iene _{eg. No.} 2008	15767
ź	Physici	an	1. Decedent's Name (First, Middle, Last) EUA LEISTER			2. Date of Deat Month	th Day Year	3. Time of Death
,	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of		13 2008 4c. County of Death	
			Northwest Hospital		Randalls		Baltime	
Ì,	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 N F 93	(In yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	8. Date of Birth (Month, Day, Dec. 6,	Year) Country	
	and ow t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			, Inside City Limits
	e Mary sa-f sh tiffed a	ctor	Maryland Baltimore	Catons	sville			1 ∐ Yes 2 MNo
	with this a or 28	Director	10e. Street and Number 303 Maiden Choice Lane #227	7	10f. Zip Code 21228		0g. Citizen of What Country USA	?
	r death ems 23 er musi	Funeral	11. Marital Status 12. Was Decedent Examed Forces?		Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican		14. Race - American Black, White, etc	
326	be filed within 72 hours after death with the Maryland Hylyiene. d other than "natural", or items 23a or 28a-f show event, the Me Iteal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:)	1 ☐ Yes 2X No Specify:		Specify: Whi	
21215-0036	"natura	Completed	15. Decedent's Education (Specify only highest grade completed)	ı (Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business/Indu	stry
1212	d within giene. rr than the M	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	stered Nurse		Hospital	
_	0 = 0 =	Be	17. Father's Name (First, Middle, Last) Joseph Mitchell		18. Mothe	er's Name (First, Middle, I	ŕ	
Maryland	2 should be to and Mental it is marked of raumatic eve	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	Nero	enika Sipavi er or Rural Route Number		ode)
Š	and 2 fealth a m 27 Is her tra		Robert Leister Son		Woodcliff Ave			
פר	ages 1 ent of H it: If Ite y or ot		20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1	matory or other place)		20c.Location - City or Town	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licenses	22	2. Name and Address of Facilities and Home of	y Sterling A	shton Schwab	
	<u>~</u> □ = ≈ ⊙		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	16	30 Edmondson	Avenue: Cato	nsville, MD	pproximate
	Physician	8. 0	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition		- , -, -, -, -, -, -, -, -, -, -, -, -, -,	,	lı C	nterval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (of as a	consequence of):	-			
	n:1 =	ner	Sequentially list conditions.	consequence of):				
	and and al-trans	Examiner		consequence of):				
8/60	ficate be executed physician and the burial-transit	edical	d					
ROX 6	certific nding plase as t	/Mec	IF FEMALE: 23c. If yes, outcome pl				23d. Date of delivery	
	w requires that the death certif been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at ti		□Ectopic pregnancy □ Other (specify)			ay Year
т. Э	requires that the een signed by th nould be detache		9 ☐ Unknown Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Part I	. 23e. Did tob	bacco use contribute to the	cause of death?
cords	equires sen sigr ould be	ted by	Empayema, Acut	- Renat	Failure	1 🗆 Ye	es 2 No 3 Probab	oly 4 🖾 🖽 Known
ပ္	The law ate has be bage 2 sh	Completed				24a. Was a autops perforr	sy prior to comp	y findings available pletion of cause of
		Be Co	25. Was case referred to medical examiner?		26. Place		2 2 No 1	ZHO
5	Physic r this ce ral dire	၉	1 Yes 2 Hospital: 1 Impatient 27. Manner of Death 28a. Date of Injury				ence 6 Other (Specify) ow injury occurred	v.
ion	ending ath. or: Afte he fune	ation	1 ☑ Matural 5 ☐ Pending (Month, Day 1 2 ☐ Accident investigation		Work? M 1 Yes 2		ow many occurred	
DIVISION	l or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc.	/ - At home, farm, str (Specify)	reet, factory, office	28f. Location (St City or Town	treet and Number or Rural F n, State)	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i		29a. Certifier (Check only 2 Medical Examiner: On the basis of e	my knowledge, deat	h occurred at the time, date an	nd place, and due to the cath occurred at the time of	ause(s) and manner as stat	ed.
	o the hithin 24 o the Formplets	Medical	one) and manner state 29b. Signature and title of certifier	ed.	00-11			
	- > - 0		A. Frafform,	MD	D6584	13	May, 13,	2008
	/	1.						
	5		30. Name and address of person who completed cause of dea Abda/loh Kafrounia, 5	th (Item 23a) (Type,	Print) Court Road	d, Randa	listown, H	D 211 ??

			For State Registrar	State	of Marylar		artment of H <i>tificate of L</i>		-	giene Reg. No.	008	15768
		-	Decedent's Name (First, Middle)	e, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		Inona P.	Lehr					Month May	10 ^{Day}	008 Year	1:00p M
	Examin		4a. Facility Name (If not institution					Location of Death			ounty of Death	
			Franklin Sc	·			Rose	edale If Under 24 Hrs.	O Data of Dia		Baltim	
r	Funeral Director		5. Social Security Number 214-20-7368	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 94	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da June	ay, Year)	Cou	place (State or Foreign Intry)
-	on-less		Usual Residence of Decedent		94				June 3	30,13		
	ryland thow	_	10a. State 10b. County			ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2√2 No
	ne Ma 8a-f s otifiec	Director		timore		Essex	1.01 71 0 1			10- 011-		
	a or 2		10e. Street and Number 1 Brett Co	urt			10f. Zip Code 2 1 2	21		-	en of What Cou JSA	antry :
	be illed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13. \	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No		4. Race - Amer	
ထ	or iter niner		1 ☐ Never Married 2 ☐ Marr	ied Armed F 1 ☐ Yes If Yes, G	2√ No		fYes, specify Cuba 1 □ Yes 2 ☑ No	in, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
9	ours a	d by	3 Widowed 4 □ Divorced	Year or l	Dates:							ite
2	"natu	Completed	15. Deceden (Specify only highe	st grade completed		16a. Deced	lent's Usual Occup: kind of work done o DO NOT use retired	ation during most of work	ding	16b. Kind 	d of Business/l	ndustry
12	withir iene. than he Me	duc	Elementary/Secondary (0-12)	College 4vrs	(1-4or 5+)	ı	emaker	/		owr	n home	
Maryland 21215-0036	ifiled I Hygi other ent, t	Be C	17. Father's Name (First, Middle,	Last)		.1		18. Mother's Nam	e (First, Middle	, Maiden S	Gurname)	
lan	should be to and Mental I marked of matic eve	To B	Venerible R	. Pope				Anna E	E.I. He	erlor	ng	
ar)	2 should and Men Is marke	Ė	19a. Informant's Name/Relations				g Address (Street					
	and ealth n 27 er tr		Thomas Lehr	/son	20h		Prospec		e Shev		cy PA ation - City or 1	
altimore,	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 □ Burial 2 □ Cremation		State T.	cemetery, crer	sition (Name of matory or other place ne Park	5/1	4/08		imore	
Ħ	permit. Page Department of Important: If any injury or once.	- 3	4 □ Donation 5 □ Other (S		7 -		2. Name and Addres		·			
Ba	Department once		Calis	Ville	mell	9		y Funer				to. MD
г	75-		23a. Part1. Enter the disease, shock, or heart failure. List	complications that	caused the dea	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
K	Physician	ĺ	Immediate Cause (Final disease or condition	1106	+ 20 w	T	ractuu	,				Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):						
	LXammer	e.	Sequentially list conditions,	b	(or as a conse	vience of						
۶.	rted nsit	mine	Sequentially list conditions, if any, leaving to innectate cause. Enter Underlying Cause (Disease or injury that initiated events		Contract of the Contract of th	4						
Ć.	ficate be executed physician and is the burial-transit	Examin	resulting in death) Last	C. Due to	(or as a conse	quence of):						
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Ó	ertifica ing ph e as th	a l	IF FEMALE:	1 1111								t
Box	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	sician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregr birth 2 ☐ Fet	aldeath 3□	Ectopic pregnancy	,		23	3d. Date of deli Month	very Day Year
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unk	gnant at time of nown	death 5L	Other (specify)					
<u> </u>	ires that the de signed by the a I be detached I	y Phys	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
rds	w requires been sign should be	ed by	Cerebrovas	cular F	Locider	1			1 🗆	Yes 2□	No 3□ Pro	obably 4 Unknown
Records,	law re as bee 2 sho	Completed	Stroke	(24a. Was			topsy findings available completion of cause of
		Com	Hypertone	100						ormed?	death? 1 ☐ Yes	
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	Physician: The lav this certificate has ral director, page 2	은	Yes 2□ No 27. Manner of Death		Inpatient 2 c	ER/Outpatier		4 Li Nursing H	ome 5 Res			cify)
Division or	ding l	ion	1 ☐ Natural 5 ☐ Pendir	g (Mo	nth, Day Year)	Injury	Wor	yan k? Yes 2N⊑(No	20d. Describe	Now injury	occurred	
<u>ISI</u>	Atten deatl	fical	Suicide 6 □ Could	not be 28e. Pho	e of injury - At h	nome, farm, str	eet, factory, office	7				ıral Route Number,
\leq	al or safter	Certification:	4 ☐ Homicide determ	buil	ding, etc. (Spec	3me			pr	wn, State)	Brett	CT
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical	ng Physician: To the	ne best of my kn	owledge, deat	h occurred at the tirvestigation, in my o	me, date and place	, and due to the	e cause(s) a	and manner as place, and due	stated. to the cause(s)
	the Ithin 24 the Ithin 24 the Ithin 1944	Medical	one) 29b. Signature and title of certifie	and ma	inner stated.		29c. Licens				signed (Montl	
	4 € €		255. Signature and the or certifie	1 DIN	1 00	,	D19	3667		Ma	1127	~~~~
		4	30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type.	Print)	1001		1 14	1 12/2	0
	6		Dis o	-TELLO	MDG	Trin	ble Hill	CT Lut	benezille	2 Mc	1210	93
	Sta		31. Date filed (Month, Day, Year) MAY 1 4	2008	Registrar's Sign	nature /	W.	• 1				
	Registi	ar	mai 14	2000	ALLEN S.	r stoo						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 7:50 A M Lutz, Jr. Howard M. 12 2008 Mav /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice Center Baltimore Co. Timonium 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Min. MXM 2 F Months Days Hours 66 219-40-6972 Director 1941 Maryland Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City. Town or Location 10a, State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Moulco Examiner must be notified at 1 ☐ Yes 2XXNo Director Rosedale Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8545 Pulaski Hwy. Lot #25 United States Funeral 21237 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ty Yes 2 No If Yes, Give Year or Dates: 72 hours after ty Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2√∑No Specify: Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ' lealth and Mental Hygiene. m 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Baltimore City Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret F. Myers ဂ္ Howard M. Lutz, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any Injury or other trau (Sister-in-Law) 9606 Magledt Road Baltimore, Maryland Betty Lutz Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility 21. Signatur of Juneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart ailure. L Immediate Cause (Final disease or condition resulting in death) **Physician** BLADDER CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending abundance and attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy this certificate has been signed by the atte al director, page 2 should be detached for Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 1 ☐ Yes 2 🗆 No 2 **X** No **Director:** After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\to \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) \(\text{HOSPICE} \) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 7008 /Medical Michael John Ladzinski Sr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** VA Maryland Nealth lame Known to Physician: Ladzinski, Micl . Social Security Number 8. Date of Birth (Month, Day, Year) 08-12-1916 Birthplace (State or Foreign Country) **Funeral** Months Hours 1 √ M 2 □ F Davs Min. 216-03-0885 91 **Director** Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner nast be ricitled at Director 1 ☐ Yes 2 4No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 600 Deep Ridge Road 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status The Tributes of the Tributes 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheer Operator stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fil f Health and Mental F Item 27 is marked otl other traumatic even John Ladzinski Emilia Bartkowska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If Item 27 i any injury or other tra once. Marie W. Ladzinski 600 Deep Ridge Road Bel Air MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 5-13-2008 Dundalk Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk Inc. 7922 Wise Avenue Dundalk Maryland 21222 art1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ementia Lyears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and sthe burial-transit death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.O. □Yes 2□No 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an After this certificate has autopsy performed? Yes 2 No page 2 No 1 □Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 To the I within 2 To the I and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10+1 30. Name and address #person who completed cause of death (Item 23a) (Type, Print) Perry Colvin M.D., VA maryland Health Care System, Perry Point, MD 24902
31. Date filed (Month, Day, Year) 32. Rylstrans Signature State MAY 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) (1)

1		1 - For State Registrar	State	of Marylar		artment of F rtificate of			giene [] Reg. No.	08	15771
Physic /Medi		1. Decedent's Name (First, Middle William P. Ler						2. Date of De Month May 5,	Day 2008	Year	3. Time of Death 6:00 AM M
Examii	ner	4a. Facility Name (If not institution 114 Woodlawn F	Road			Bal	r Location of Dea		4c. County	of Death	
Funeral Director		5. Social Security Number 199-03-4581 Usual Residence of Decedent	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 90	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, 1918	9. Birthp Cour Mary	lace (State or Foreign Land
Maryland a-f ehow	tor	10a, State 10b, County			ity, Town or Lo					1	0d. Inside City Limits Y☐ Yes 2 ☐ No
th with the 23s or 28	ai Director	10e. Street and Number 114 Woodlawn R	oad			10f. Zip Code 212	10		10g. Citizen of USA		ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, ir a Medical Examina must be untilled at ance.	by Funerai	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Agmed F	2 No ive tπ.rt:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2√2 No	Hispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		ce - Americ ck, White, y: wh	
thin 72 hou e. en "natural Medical E	Completed b	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed,	Julio 0.	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of w d)	-	16b. Kind of B		-
be filed winter Hygien of other the	Be	12 17. Father's Name (First, Middle, I William Lentz	•		ele	ctrical	18. Mother's Na	ame (First, Middle orie Parm	, Maiden Surnar	ultin me)	.g
and 2 should ealth and Mer n 27 le marku	2	19a. Informant's Name/Relationsh Frances Lentz/	nip (Type, Print)		19b. Mailir 114	ng Address <i>(Street</i> Woodlawn	and Number or F	Rural Route Numb	er, City or Town,	, State, Zip 210	Code)
Pages 1 ar nent of Hea int: If frem iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (St				sition (Name of natory or other pla	ce)	Date	20c. Location	- City or To	own, State
permit. Depertra Imports any Inju		21. Signature Funeral Service Ronal d	wade.	irector		State And Baltimore		ard 655 1201	W. Balt:	imore	Street
Physician /Medical		23a. Part 1 Enter the disease or shock or heart allure. List of Immediate Cause (Final disease or condition resulting in death)	a	caused the dea pach line. Owned (or as a consec	1 Ma	er the mode of dyin	ng, such as carda	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
icate be executed by physicien and burial-transit sthe burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	с.	(or as a consec							
he death certifica the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregn birth 2 Teta nant at time of a nown	al death 3 □	Ectopic pregnancy Other (specify)	,			ite of delive	ary Day Year
quires that t n signed by uld be deta	by	Part II. Other significant conditio	ns contributing to c	leath but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did t	_ /	tribute to th	ne cause of death?
The law red ete has bee page 2 sho	Completed								psy prmed2	Were auto prior to col death? 1 Yes	psy findings available mpletion of cause of 2 No
To the Hoepital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending investig	28a. Date (Mor		ER/Outpatier 28b. Time of Injury	28c. Injui Wor	er: 4 Nursing	Home 5 A resi 28d. Describe			у)
al or Attens after deal	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of Injury - At h ling, etc. <i>(Speci</i>	nome, larm, str	eet, factory, office		28l. Location (City or To	Street and Numb wn, State)	ber or Rura	al Route Number,
the Hospit in 24 hour the Funari pletely fills	edical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the Examiner: On the band man	a bast of my kn casis of examina nner stated.	owledge, deati ation and/or in	vestigation, in my o	pinion, death occ	curred at the time,	date and place,	and due to	tateu. o the cause(s)
To T com	Σ	29b. Signature and title of certifier	en m				H69		29d. Date signe	4 (Month, 7, 20	
Sta	10	30. Name and address of person's	mo 1	se of death (Iter	1. Charles	Print) It #56	s T	Jusu 1	0 2120	4	
Sta Registi		MAY 1 4 20	US DERE	w 15	Spark	28					

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician HARVARD FRANKLYN MILLER 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL THE DOVE HOUSE WISTMINSTER If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 403 40 5606 73 JULYE 27 Director WEST VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No notified MD REISTERSTOWN Funeral Director BALTIMORS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be 3548 AUNDAU 15000 2113 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHURCH MINISTE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EUELYN JOHNSON ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AM GUOTZUTZISM AS ENGLUAL TZAS PHYLLIS MILLER Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MANDUCE BUDGE STAM ESTAINS SIFTS FILLIFORM 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
AUTOW (LIFTS PACISTRY
7532 CONNEUEY DR. H 21. Signature of Fureral Service Licensee BE HANDUR, MA 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC COLON CARCINOMA MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) HOSPICE GACILIT Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Kath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 001663 mo 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

State Registrar

11250

31. Date filed (Month, Day, Year)

ENT

DHMH 17 Rev 1/2001

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0000 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 **Physician** Day 11 2008 10:25 Mills Dannie Mae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harborside Health Care N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12-25-1916 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 K F Days Min. 91 N.C. **Director** 133-18-2262 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 28a-f MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 4700 Harford Road 21214 U S Α or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2X No Black Completed by If Yes, Give Year or Dates: Specify: 3€Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) DOMESTIC I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Homes llth grade <u>Private Duty</u> N/A permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pierce Laura Pierce James ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8261 Highway 561 Halifax, N.C. 27839 Violetina H. Mullenš Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-16-2008 Arbutus Memorial Arbutus, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East l on 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 21202 E. North Avenue Balto, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□No 24a. Was an autopsy performed res 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yana Dange Bal N. Eutaw Street, #308, Ballimore M221201 egistrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Dorothy M. McQuade 12, 1:20 PM May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dove House Westminster Carroll 8. Date of Birth (Month, Day, Young, 21, Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🖾 F 218-18-5469 1922 Maryland Director 86 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Evandum ruust be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Cherrydale Road 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 alth and Mental Hygiene.
27 is marked other than "rer traumatic event, its made. Elementary/Secondary (0-12) College (1-4or 5+) Credit Supervisor Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hutchins Grace Sloat ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr Douglas N. McQuade Son 601 Poole Road; Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cemetery 5/15/2008 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 10/290 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in its later as a series of the control of the contr Physician/Medical Examiner Due to (or as a consequence of) burial-transit nellanomia that initiated events resulting in death) Last Due to (or as a consequence of) the as IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? for Dav 5 Other (specify) detached 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 □Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Lether (Specify) 00 LE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death HOWIE 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

or Attending Physician: The law requires that the death certificate be executed and / P.O. Box 68760. attending physician the ģ Division of Vital Records, certificate has After this To the moor after death.

To the Funeral Director: Af Hospital

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Certification: To 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** -lovence Moure 2008 5:50p May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Nursing & Rehab Laurel Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🙀 F 212-32-3820 101 Director MD Apr 12 1907 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Elkridge 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21075 7140 Stones Throw Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black à 3 ☐ Widowed 4 🂢 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) foodservice Elementary/Secondary (0-12) College (1-4or 5+) cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Lee Williams Ellen Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Randall (nephew) 14154 Holler Rd., Alpena, AK 72611 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) tX Burial 2 □ Cremation 3 □ Removal from State Bushy Park Cemetery 5-16-08 Cooksville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Dauge Hougert Sterkert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specity) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>À</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specity) 2 No 3□ DOA ۴ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, MD 20707 13635 Baltimore Ave, DARRYL HILL M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 20b, perFH, g879 5/14/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:38 AM 9, 2008 Elizabeth H. Monroe May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5315 Wapakoneta Rd. Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 88 Director 228-28-8294 06/02/1919 VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at Director 1 Nes 2 No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 20816-United States 5315 Wapakoneta Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status "natural", or item: ledical Examiner r Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be fill.
Health and Mental H
tem 27 Is marked oth Be David Alexander Harrison Jr. Elizabeth Beale Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any injury or other trau Willam Blanc Monroe/Husband 5315 Wapakoneta Rd. Bethesda, MD 20816-Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State तेयव Beltsville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Rapp Funeral & Cremation Services Rapp Funeral & Cremation Serve 933 Gist Ave. Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave. Silver Spring, Maryland 20910-Immediate Cause (Final disease or condition resulting in death) ASPIRATION Physician /Medical Due to (or as a consequence of): Examiner DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner be executed DEMENTIA burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ADULT ONSET 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate 1∐ Yes Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident or Attending (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No the f after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

MILLER

DHMH 17 Rev 1/2001

29c. License number

D35579

8218 WISCONSIN AVE: #305, BETHESDA MID 20816

29d. Date signed (Month, Day, Year)

2008

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Be

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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127 is marked other than "1 traumatic event"

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Pages

the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Hospital or Attending

or other

Department of H important: if ite any injury or of once.

the Medical

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine and I-tran signed by After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

dical		■ d								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3⊟Ectopio 5⊟Other	c pregnancy (specify)		23d. Date of delivery Month Day Year				
ted by Pl	Part II. Other significant conditions of Diabetes Mellitu		n the underlyin	g cause given in Part I.		cco use contribute to the cause of death?				
Completed by	Hypertension				24a. Was an autopsy performe 1∐ Yes 2 ☑	24b. Were autopsy findings available prior to completion of cause of d? death? ¶No 1 □ Yes 2 □ No				
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
2	1 ☐ Yes 2 🔏 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3□	DOA Other: 4 Nursing I	Home 5 Residence	ee 6 ☐Other (Specify)				
	27. Manner of Death 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, for building, etc. (Specify)	arm, street, fact	tory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)				
Medical C										
ž	29b. Signature and title of certifier			29c. License number	29d	. Date signed (Month, Day, Year)				
	1/2m	ma Mn		D-32332	Ma	y 12, 2008				

9801 Georgia Avenue Ste 220 Silver Spring, MD

20902

Registrar DHMH 17 Rev 1/2001

State

istrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

SURESH K. GUPTA MD

31. Date filed (Month)

		State of Maryland / Department of Health a		tal Hygie	ene 2008	15778	
		Registrar Certificate Of Death	120	Reg	. No. C U U U	2 Time of Dooth	
Physici /Medic		1. Decedent's Name (First, Middle, Last) Elsie Irene Mitchell	_ N	Month ay 12	Day 2008 Year	3. Time of Death 6:25a ^M	
Examir	ier		4b. City, Town, or Location of Death 4c. County of Dea				
	- 2	Ivy Hall Nursing Center Middle Ri					
Funeral		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	24 Hrs. 8. D	ate of Birth Month, Day, Y	(ear) 9. Birth	place (State or Foreign	
Director			JI	une 1	8,1949	Virginia	
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
Aaryl F sho	ō	MD Baltimore Essex				1 □Yes 2√□No	
the 1	ect	10e. Street and Number 10f. Zip Code		100	. Citizen of What Cou	otry?	
with a or	Funeral Director	602 High Villa Road 21221		1.05	USA		
eath 1s 23 musi	era			Ves or No-	14. Race - Americ	can Indian.	
fter d	F	Armed Forces? If Yes, specify Cuban, Mexican	n, Puerto Ricar	n, etc.)	Black, White,		
hours af	by	1 ☐ Never Married 2X Married 1 ☐ Yes 2 ▼ No If Yes, Give 1 ☐ Yes 2 ▼ No Specify: Year or Dates:			Specify: Whi	.te	
2-to	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most	at a formation	16	6b. Kind of Business/Ir	dustry	
thin 7	Jple	Flementary/Secondary (0.12) College (1.4or 54) life. DO NOT use retired)	a or working				
od wi	Co	5th Homemaker			own home		
be file doth even	Be				niden Surname)		
at yidilid AIAID-DUDOO should be filed within 72 hours after death with the Maryland nd Mental Hyglene. i marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ဥ				Hall Tu:		
2 short and is m		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Numbe				′ 1	
and and tealth m 27		Paul Mitchell / husband 602 High Villa					
DESILITIOTE, INICITYICITY Z IZ IS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Deposition (Specific) 1 Burial 2 Cremation 3 Removal from State 4 Deposition (Specific)	Date	- 1	oc. Location - City or T Baltimor		
Dallimor Department of Mportant: If it any injury or once.		4 Donardi S Done (Specify)	_				
Department of the popular of the pop		21. Signature of Fundal Service Dicensee 22. Name and Address of Facility	_A 300 J	Mace A	Ave. Balt	imore MD	
		23a Part1 Enter the disease or complications that caused the death. Do not enter the mode of duing such as				21221 Approximate	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause of each line. Immediate Cause (Final				Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	i m	Evec	un		
Examiner		Due to (or as a consequence of):	alla	R	İ		
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
ansit a fet L	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C					
exec an an rial-tr		Due to (or as a consequence of):					
ite be exe	ca	d. Umme Renal	mm	Me	ng		
rtifical	Physician/Medi			1 A	1		
ath cer attendin or use	an/l	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□Ectopic pregnancy			23d. Date of deliv	,	
bedea heat ed fo	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year	
at the	Phy	9 Li Unknown					
res the signer be d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dustul Escrippe und The work of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dustul Escrippe und The work of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.			cco use contribute to		
ecords law requires as been sign 2 should be	Completed	Brace of the cool of the		1 169	2010 3070	Dably 4 DONKHOWN	
e law has b	du		'	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of	
cate cate pag				performe 1∐ Yes 2	ed? death?	2 No	
VICAL sician: T certificat rector, pa	Be	examiner: Hospital: Other:	e of Death (Ch				
Phys r this ral dir	2	I Inpatient 2 EH/Outpatient 3 DOA 4 Nu			ce 6 Other (Spec	ify)	
ding ding After funer	ioi	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work?		Describe nov	injury occurred		
VISION Attending or death. rector: Afte	icat	3 Suicide 6 Could not be		ocation (Stre	eet and Number or Rui	ral Route Number	
Jor A affer Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,		ai riodie Nambei,	
spita lours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an	nd place, and o	due to the cau	use(s) and manner as	stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea one) and manner stated.	ath occurred at	t the time, da	te and place, and due	to the cause(s)	
Within To 11	Me	29b. Signature and title of certifier 29c. License number		29	d. Date signed (Month	, Day, Year)	
		1 Ethor MI) D3146	04		5/13	(08	
1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4 ~	0.0	A 1		
1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOALIS A. HASHMI, & 2 (N. EMTAW ST Sw. 31. Date filed (Month, Day, Year) MAY 1 4 2008 32. Registrar's Signature	NU 50	11/15	47 ((Wal	LE MD 21	
Sta		31. Date filed (Month, Day, Year) MAY 1 4 2008 33. Registrar's Signature					
Regist	rai						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Louis Kane Mitchell 8, 2008 1:28F M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Baltimore Towson Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 6, 1941 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Maryland 218-36-1746 XXM 2□F 67 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Baltimore N/A 1X∑X*es 2 □ No MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21239 1361 Winston Avenue death w Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner. once. 1 ☐ Never Married 2 X Married Specify: Black 1 ☐ Yes X No Specify: Baltimore, Maryland 21215-0036 à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Morgan State Elementary/Secondary (0-12) College (1-4or 5+) University Bus Driver 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Partenia Kane James Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type. Print) 1361 Winston Avenue Baltimore, MD 21239 Sallie Brewer-Mitchell/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/12/98 20a. Method of Disposition Maryland Nat'l. Mem. Park N Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licenses 21206 4210 Belair Road Baltimore, MD arres 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAY CARDIOGENIC SHOCK **Physician** /Medical Due to (or as a consequence of): 1 DAY ACUTE MYOCARDIAL INFARCTION **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 □ No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should be SEVERE ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣No 24a. Was an autopsy has 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Other: Hospital: 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and the of certifier

6

State Registrar

TIMOTHY LOW M.D. 31. Date filed (Month, Day, Year) 4 2008

MAY 1

DRIVE, TOWSON, MARYLAND 21204 OSLER 7601 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D24034

	1	State of Maryland / E - State Registrar	Department of Heal Certificate of Dea			ene g. No. 200	8 15780
Physicia	an	1. Decedent's Name (First, Middle, Last) Vera N. Mac	ck		2. Date of Death Month May 5,	Day Ye	ar 9:30 A M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 1908 Gaither Street	4b. City, Town, or Loca Temple Hi			4c. County of D	e George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 1 M 2√√√ 81		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, May 11,	Year) 9. 1926 W	Birthplace (State or Foreign Country) ashington DC
TO		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
Maryl -f sho	ţo	Maryland Prince George's Temp1	e Hills				1 □Yes 2□No
r 28a	Director	10e. Street and Number	10f. Zip Code		10	Og. Citizen of Wha	
th wit 23a o 1st be		1908 Gaither Street	20748			United S	tates
portition of the property of t	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☑ No Sp	nic Origin? (Spec Nexican, Puerto F pecity:	oify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White
in 72 hour	Completed b	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	n ng most of workin		l 16b. Kind of Busin	
d withing giene.	mo:	Elementary/Secondary (0-12) College (1-4or 5+)	lomemaker			Own Hom	e
late tiled the tiled fental Hygerked otheric event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) John William Glascoe	18.		(First, Middle, N 'y Maud	Maiden Surname) Tucker	
2 shou and N is mai		, , ,	. Mailing Address (Street and I	Number or Rura	Route Number	City or Town, Sta	te, Zip Code)
and land lealth mm 27 ther tr			898 Lynn Crest Disposition (Name of			a, MD 21 20c. Location - Cit	
ages int of h		1 ☐ Buria! 2 ☑ ☑ remation 3 ☐ Removal from State cemete	ry, crematory or other place)				
mit. P partme portani y injury		21. Signature of Fineral Service Licensee	ee Crematory Ma	ay; 0, 20	Funeral	Clinto Home, I	nc 6633 Old
		* Koglet Magen 963	Alexandria Fe				20735
Physician		23a. Part1. Enty the elease, or complications that caused the death. Do shock, or eartifure. List only one cause on each line. Immediate Ause (binal disease or condition	levetu Cordi				Approximate Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence					
od sit	iner	Sequentially list conditions, if any, Isaum printed cause. Enter Underlying Cause (Disease or injury that initiated events	30:				
icate be executed physician and the burial-transit	Examiner	cause (Disease of Hilly) that initiated events resulting in death) Last C. Due to (or as a consequence	of):				
portoricate by physic s the bu	edical	d					
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 1	n 3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of Month	
ires that the signed by the detaction	þ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in	n Part I.		bacco use contribu	ute to the cause of death?
w requires to been signed should be	letec	11 habelemia			24a. Was a	n 24b. We	re autopsy findings available
The la The la ate has page 2	Completed	778/2 310/2001			autops perform	med? dea	or to completion of cause of ath?]Yes 2□ No
VICAL Iclan: Sertifical ector, p	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	6. Place of Death	(Check only of	ie)	
JI OF OF Siling Physics After this of funeral directions of the siling o	ion: To	27. Manner of leath 28a. Date of Injury (Month, Day Year) 28b.	Time of lnjury at Work?			ence 6 Other ow injury occurred	
or Attending after death. Director: After in by the fune	Certification:	☐ Accident investigation 3☐ Suicide 6☐ Could not be determined 28e. Place of injury - At home, fix building, etc. (Specify)			28f. Location (S. City or Town	treet and Number n, State)	or Rural Route Number,
Hospital 24 hours 5 Funeral etely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination a and manner stated.					
To the within To the compl	Me	29b. Signature and title of certifier	29c. License nu			29d. Date signed (
		Jegu /	1 > 2	1878	5	MAY	6,2008
5		30. Name and address of person who completed cause of death (Item 23a) NETTON BENTENS, 9131 & 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(Type, Print) 13 CATAWAY	ROAD,	CLIN	TON, A	1) 20735
Sta Regist		31. Date filed (Month, Day, Year) 32. Begistrar's Signature MAY 1 4 2008	Rose M. A				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend 4a, perMD, C879 5/14/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** 15 13 9 2005 Thomas Newman May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3620 Hilmar Road andallston Baltimore ON HIEMER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1**X**M 2□ F Director 68 10/11/1939 213-36-3113 Maryland Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Baltimore Randallstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r 21144 U.S.A. 3620 Hilmar Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? Unknown

14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

16. Yes 2 ★ No Specify: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 ğ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Track Foreman Amtrak 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas O. Newman Noni Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type. Print) 9401 Wordsworth Way, Unit 106, Owings Mills, Md e of Disposition (Name of Date 20c. Location - City or Town, State Donna Newman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/14/2008 Baltimore, Maryland King Mem. Park Ceme. 21. Signature of Funeral Service Voense 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chrone ORSTRUCTURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☑ No 24a. Was an autopsy performed? res 2 No 1□ Yes To the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specity) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred s after dea. rai Director: Aft Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 029085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 COURT . Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

1 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:00 AM ENN MONROE PEREGOY MAY 200B /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 19439 MOLBERT MAY BALTIMORE BRADSHAW 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 18 M 2□ F Days 315-76-7642 Usual Residence of Decedent APRIL.30, 1957 Director MARYLAND Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director MD BRADSHAW BALTIMORY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19426 WOLRART 2108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: WHITE 3 □ Widowed 4 □ Divorced Completed r than "natur the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) SUPFIXISOR STATE GOVERNMENT MAINTENANCE 77 Is marked other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PEREGOY LIEBERMAN CAMSION EILEEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any Injury or other trau 12426 BRUDSHAUMS SPOUSE WOLBURT WAY, 31087 MARGUE A. PEREGOY 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State HANOURR, MARYILAUS MAY 13 2008 4 ☐ Donation 5 ☐ Other (Specify) ARDGUT CIRLYATORY 21. Signature of Emeral Service Licensee 22. Name and Address of Facility COTANANT THEOSIA 21076 DIZIUS, HALDUIL, MIS Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Non mall Canal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending plant of the last as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No or Vital Records, P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1□ Yes 2□ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Irrector: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 and d

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Pull

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JOHNS HOPKIN 31. Date filed (Month, Day, Year) 5 01) & 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 8 per fth 8879 5-22-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:00 PM M 2008 May 8, Jacob Peoples /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth **()8**17th, **1**145 Yea*r)* **05/18/**1948 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Country) 1**⊠** M 2□ F 59 FL Director 265-88-1967 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director **Brentwood** Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20722-4142 Bunker Hill Rd. Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Vietns Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or fter any injury or other traumatic event. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Yes, Give Vietnam Specify Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) (Unknown) (Unknown) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Mills Fred Peoples 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4142 Bunker Hill Rd. Brentwood, MD 20722-Barbara Hall Peoples/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 13 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature M00382 What do complications that cal Silver Spring, Maryland 20910-933 Gist Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** せらど /Medical resulting in death) Due to (or as a consequence of) Examiner PENTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician by Physician/Medical as the attending IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ь in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2☐No be detached the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an has autopsy performed Yes No this certificate 1 | Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referre medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No No 14 Impatient 2 ER/Outpatient 3□ DOA Ė Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Leath 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 ☐ Accident the 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification

Registrar
DHMH 17 Rev 1/2001

State

and add

31. Date filed (Month, Day,

ess of person who completed cause of death

2008

Year)

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32. Registrar's Signature

(Item 23a) (Type, Print)

08-03531 Mary L. Price Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ry L. Price		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No.											
Physician/		Registrar 1. Decedent's Name (First, Middle,L	.ast)					2. Date of De	ath		3. Time of Death		
dical Examin	ner	Marv	Lucille	<u> </u>		ice		Month May 8, 2		Year	1648 hrs		
-6.		4a. Facility Name (if not institution, give street and number) 5022 Pembridge Avenue			4b. City, Town, or Location of Death Baltimore			ath	40	c. County of Death			
Funeral		Social Security Number 6.	In yrs. last birthday)				Hrs. 8. Date of E	Birth(MM	(MM/DD/YYYY) 9. Birthplace (State or				
Director		239-32-1421 1	Months /rs.	Days	Hours N	^{din.} 06 (06 03 20		Foreign Country) NC				
Ą.		Usual Residence of Decedent 10a. State 10b. County	110	Oc. City, Town or Lo	cation						10d. Inside City Limits		
d now any											1X Yes 2 No		
aryland	Director	10e. Street and Number		10f. Zip Code				10g. Cit	tizen of What Cour	itry?			
vith the Maryland s 23a or 28a-f show a e notified at once.	ä	5022 Pembridg		21215					U.S.A	•			
h with	Funeral	11. Marital Status	12. Was Decedent E				(Specify Yes or Nerto Rican, etc.)	No-	14. Race - American Indian, Black, White, etc.				
or deat	Fun	Never Married 2 X Married		X No 1 Yes 2 X No specify:				, , ,	i	Specify: B1	Black		
urs afte tural"	d b	15. Decedent's Education (Specify	eted) 16a. Deced	Decedent's Usual Occupation (Give kind of work done				16b. Kind of Business/Industry					
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within iene.	Completed	l2th grade	na	S	eamst			(First Middle	Maidan	Priv	ate		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Be Co												
2121 ould be fi Mental I marked ic event,	ToB	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
e, MD I and 2 sho Health and item 27 is		James Price-H	Iusband							more, M			
of Hea		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State		other place)			Date		. Location - City or	·		
timent trant:		4 Donation 5 Other Spec			dlawn			/14/08	Ва	altimor	e Co., Md		
Baltimore, permit. Pages 1 and Department of Heal Important: If item injury or other tra		21. Si nature if Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215											
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and											
/Medical Examiner	ner	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Death											
		or condition resulting in death) Due to (or as a consequence of):											
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
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o, e be exe ysician burial -	edical	UNPENDED AMENDED											
876 tificate ng phy	n/M	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month							y Day Year				
Box 68760, edeath certificate be the attending physic ed for use as the bur	/sician/M	past 12 months? 1 Yes 2 ✔ No 9 Unknown	Pregnant at til		Other (Speci	fy)			12003				
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ires that the signed by the detaction	þ	à								1 Yes 2 No 3 Probably 4 Unknown			
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on of anding Ph th. r: After t	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No											
Division tal or Attendin is after death. al Director: A led in by the fu	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City											
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Division of Vital Records, P.O. Box 68760, To the Hospital or entificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
To t To t	Medical	and manner stated. 29tr Synature/and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)			
		() (she (M)			O.C.M.E.				May 12, 2008				
5	9	30 Name and address of person who completed cause of death (Item 23a)											
	4 4	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Manth, Day, Year) 32 Registrar's Signature											
St Regist	ate trar	31. Date filed (Month, Day, Year) MAY 1 4 2	008 32 Registrars		and I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 0^{Day} 17:15 M Phillips D. Wanda /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4001 Clarks Lane Apt 416 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 52 Director 218-64-2276 Usual Residence of Decedent 14 55 Germany filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be muffled at Xॉॉॅ Yes 2 ☐ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 4001 Clarks Lane Apt 416 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes A No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12th grade ntary/Secondary (0-12) College (1-4or 5+) Supervisor Hospital marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Phillips Barbara Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Phillips-Sister 3016 Fallstaff Manor Ct, Baltimore, Md 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Mt. Zion 5/14/08 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee Thompson rome. 21215 4300 Wabash Ave, Baltimore, Md ++-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final aney disease Physician nd /Medical resulting in death) Due to (or as a consequence) Examiner 12re Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed modia attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) the The law requires that the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform eceni 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 TAccident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours at Funeral D etely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier ical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

31. Date filed (Month, Day, 1947)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 830 Month Day Robert Grant Prettyman, Sr. 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death dale TIMORE Franklin Dai Jare If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Unde Birthplace (State or Foreign Country) Days Year) Months 1X M 2 □ F Hours Yrs. 213-32-8815 11-23-34 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Overlea 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 4417 Glenmore Avenue 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 1▼TYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 years Machinist/mechanic Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Prettyman Orpha Mae Not known 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Helmick (Daughter) 4417 Glenmore Avenue Overlea, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5-12-2008 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 2122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): rand Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). 10 Due to (or as a consequence of) aemic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 Tes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

T is mark id other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exa all as must be redited at

Department of Health and Mental Hygiene. Important: If item 27 is mark in other than any Injury or other frammer.

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Pages 1 and 2

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Funeral Director

Completed by

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be detached signed by funeral director, page 2 should been has certificate this After t

Physician: The law requires that the death certificate be executed P.O. Box 68760, Attending death. after death the filled in by ō

Division of Vital Records.

Examiner Physician/Medical ş Completed Be Certification: To

within 24 hours a

To the Hospital

State Registrar

Medical

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Kinpatient $4 \square$ Nursing Home $5 \square$ Residence $6 \underline{\ \ \ }$ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Matural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 0 0055171

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square Drive Baltimore MD, 21237 9000 Franklin Sebastian

DHMH 17 Rev 1/2001

aftending physician and death certificate be exec Division or Vital Records, P.O. Box 68760 the as use cate has been signed by the after page 2 should be detached for

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAPAY 8, 21/10/8 Physician 9:22A M Richard Louis Palardy Sr. /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Center Joseph Medical Saint If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year)
Oct. 31, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 12 M 2□ F Maryland 219-18-6892 82 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9 Forest Drive 21014 <u>USA</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. þ 3 Widowed 4 Divorced White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Joseph Palardy Frances Ann Mueller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Forest Drive, Bel Air, Maryland 21014 Pat W. Palardy / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 5-12-08 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. ass 50 W. Broadway, Bel Air, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NON ST ELEVATION MYOCARDIAL INFARCTION Physician /Medical Due to (or as a consequence of) Examiner ARTERY DISEASE CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐ Yes 2☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 💢 Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 ☐ Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24034 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON MARYLAND 21204 OW 31. Date filed (Month, Day, Year) M 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

Registrar

29b. Signature

30. Name and Addre 000

31. Date filed (Month, Day,

Year)

2008 4

0016263

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State Registrar Amend 19a,perFH,g879 5/14/08 TT Certificate of Death Decedent's Name (First, Middle, La 2. Date of Death 3. Time of Death Month Physician ucinda 606 AM 2008 May 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner AGNES BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-34-2762 Months 1 □ M 2 X F Director Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show VA 1 ☐ Yes 2 No **Funeral Director** inia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5205 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, The Medical Examinar Armed Forces Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 KNo Specify: Black à 3 Widowed 4 □ Divorced Year or Dates: natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life DO NOT use retired) then College (1-4or 5+) abover Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nilliam ewis)ackson 19b. Mailing A Informant's Name/Relationship (Type, Print) ane, Vi 5205 C Health a altimore, 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 Department of important: if eny injury or once. Owings Mills, and 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service and Address of Gacillo reene Funeral Services Kreen Baltimore Next' 1 P.16 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hythmia unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine sicien and burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 moeths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 🗆 No 1 ☐ Yes Vital To the Hospital or Attending Physician: 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ð 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funerei Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by etermined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H62862 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
All Ce Tang 900 South Caton 1 "Ave. Baltimore, MD 21229 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 4 2008 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Olive Virginia Ray 2008 May 10, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 85 216-12-8228 Director May 16, 1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location injury or other traumatic event, the the dight Examiner must be notified at Director Maryland Anne Arundel Glen Burnie 10g, Citizen of What Country? 10e. Street and Number 10f Zin Code 902 Stewart Ave. 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Walter Frank Piner Lora Catherine Bennett ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau once. 902 Stewart Ave., Glen Burnie, Maryland 21061 Lori Rogers/ Daughter 2008 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖺 durial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
21 Crain Hwy., S.E., Glen Burnie, MD 21061 re of Funeral Service 23a. Part 1. Priter th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition INFARCTION CArcus

Physician /Medical Examiner

P.O. Box 68760.

the Hospital or Attending Physician: The law requires that the death certificate be

after death Director:

within 24 hours a

To the Funeral I

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Completed

Be

Certification: To

Medical

Division of Vital Records.

	resulting in death) Sequentially list conditions,	b. =
Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c d
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√No 9 □ Unknown	23c.
죠	Port II Other elegificant condition	o contrib

IF FEMALE:	
23b. Was decedent pregnant	
in the past 12 months?	
1 ☐ Yes 2 ☑ No	
g 🗆 Unknown	

23c.					regna	
	1 🗆 1	ive hi	rth	2 [Fetal	d

leath

Due (or as a consequence of):

Due to (or as a consequence of)

1 Ab ctes

- 4 ☐ Pregnant at time of death g ☐ Unknown
- 3 Ectopic pregnancy

Mellitu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Iday

3. Time of Death

9. Birthplace (State or Foreign Country) West Virginia

10d. Inside City Limits

1 □ Yes 2 X No

5:20 P M

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes	2] No	3∏ Prol	bably	4 Unknown
 Was an autopsy		24b.	Were auto	psy fir	ndings available on of cause of
performed			death?	. I	vla.

4b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No

25	. Was case referred to medica
	examiner?
	1 ☐ Yes 2 No
27	Mannor of Dooth

Natural 2 Accident

3 Sulcide 4 Homicide

5 Pending investigation 6 ☐ Could not be

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature and title of certifier

4

Washington Medical Center Name and address of person who completed cause of death (Item 23a) (Type, Print) FR AWCI

31. Date filed (Month, Day, Year) MAY

V

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. Day Year **Physician** Jose Rosorio Mav 2008 6:30p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Carrol1 Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □**Y**M 2 □ F 71 none Yrs El Salvador DEc Director 12 1936 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified at MD Carrol1 Svkesville 1 ∐Yes 2 _XNo Director 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? ō 21784 El Salvador 6655 Sykesville Road items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2□ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other thin any Injury or other terminants. unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springfield Hospital Records 6655 Sykesville Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Springfield Cem. 5-7-08 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilitHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Harger Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 4/23/05-5-608 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 1 □ Yes 24a. Was an performed? 2 1204 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospur blue 1 Tes 2710 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 14

Registrar

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 15792

		1- For State Registrar	Ce	rtificate o	f Death			Reg. No.		
Physicia	an/	1. Decedent's Name (First, Middle,Last)					2. Date of De Month	Dav	Year 3	3. Time of Death
edical Exami	ner	HAYWOOD RHOD					May 12,	2008		1452 hrs
*		4a. Facility Name (if not institution, give st University Hospital	reet and number)		4b. City, Town, or Lo Baltimore	ocation of Dea	ath	4c. Cour	nty of Death	
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		Irs. 8. Date of E		YYY) 9. Birth Foreign	
Director		219-94-8911 1XM	2 F 28	01-0	3–1980	Cour	ntry) MD			
b		Usual Residence of Decedent 10a. State 10b. County	Inc. Cit	y, Town or Loca	tion					10d. Inside City Limits
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daryland 28a-f show Lat once,	흱	MD 10e. Street and Number	1	BALTIMOI	10f. Zip Code			10g. Citizen of		7
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)	-		178				ame)	
2121 buld be fil Mental F marked c event, J	To Be	HAYWOOD RHODES, I		19b. Mailir	ng Address (Street		TINE RUP or Rural Route N		Town, State,	Zip Code)
sho and 7 is		SALLY SIMPSON/ADO	PT. MOTHER	1.0	23 N. FULT			-		
		20a. Method of Disposition	20b		sition (Name of cem		Date		tion - City or T	
More Pages 1 then of Home of Home of Home of Home of Home of Home of Home of Home of Home of Home of the tent of t		1 X Burial 2 Cremation 3		_	ORIAL PARI	, ,	5_19_200	RAT.	TTMORE	, MARYLAND
Baltimore, permit. Pages I an Department of Het Important: If ite		Donation 5 Other Specify: 21 Signature of Funeral Service Licensee								S F.H., INC.
		James 9.7	nexton	1	1701-31 L	AURENS	ST. BA	LTIMOR	E, MD	21217
Physician		23a Part I. Enter the disease, or complicate failure. List only one cause on each	tions that caused the deat line.	h. Do not enter	the mode of dying, s	such as cardia	c or respiratory a	arrest, shock, o	r heart	Approximate Interval Between Onset and
/Medical ⊏xaminer	1 1	Immediate Cause (Final disease a. Mt	ultiple Gunshot Wou	ınds with Co	mplications					Death
		or condition resulting in death)	e to (or as a consequence	of):						
	ē	Sequentially list conditions, if any, leading to immediate Du	e to (or as a consequence	of):						
7	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		7						
cuted and transit	Ä	events resulting in death) Last d.	e to (or as a consequence	of):						
š	ical		MENDED						-	
8760, ificate be ex ig physician	n/Medical		23c. If yes, outcome of pre	egnancy				23d. Da	te of delivery	
68760, certificate b nding physics se as the bu	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 🔲 F	etal death 3	Ectopic pres	gnancy	Mon	th D	ay Year
Box 687 ne death certific the attending p	Physicia	1 Yes 2 No 9 Unknown	4 Pregnant at time of c	death 5 (other (Specify)					
D. B trithe de by the	Phy	Part II. Other significant conditions		resulting in the	underlying cause gi	ven in Part I.	23e. Dio	tobacco use o	contribute to t	he cause of death?
P.O. es that the gened by	ģ		J	-			1 \	res 2 ✓ No	3 Proba	ably 4 Unknown
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COF	臣				· · · · · · · · · · · · · · · · · · ·		pe	topsy rformed?	death?	ompletion of cause of
tal Recian: The		25. Was case referred to medical			26 Place	of Death (Che	ck only one)	s 2 No	1 🗸 Ye	s 2 No
/ital	Be	examiner? Hos	pital: 1 / Inpatient 2	ER/Outpatie		Othor:	rsing Home 5	Residence	6 Other:	
Division of Vital Records, tale or Attending Physician: The law require at each death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a	<u>۲</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	f Injury 28c. Injury	y at Work?		e how injury o	ccurred	
OD on ath.	tio	1 Natural 5 Pending	May 2, 2008	2252 hrs	1 Y	es 2 🗸 No	Subject sl	not		
Vision Att	fica	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, str	eet, factory, office bu	uilding, etc.	28f. Location or Town		lumber or Rur	ral Route Number, City
pital O	Certification:	4 Homicide determined	(Specify) Local Stre	eet			Lauretta Av	enue & N. Fr	ranklintown	Road, Baltimore, MD
e Hos 24 ho e Fun		29a. Certifier 1 Certifying Physician	: To the best of my knowle	edge, death occ	urred at the time, dat	te and place, a	and due to the ca	ause(s) and ma	inner as state	ed.
Division of Vital Records, P.O. Box 6: To the Bospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical		n the basis of examination nd manner stated.	and/or investig			eu at the time, da			
	Σ	29b. Signature and title of certifier			29c. License					nth, Day, Year)
		four yes	3 Mis		O.C.N	vi.⊏.		May 13	, 2000	
1,		30. Name and address of person who cor Tasha Greenberg MD. As	nplited cause of death (Ite sistant Medical Exal		1 Penn Street, E	Raltimore	MD 21201			
7		31. Date filed (Month, Day, Year)	32. Registrar's Signa		facel 1		2 1201	-		
Regis	tate trar	MAY 14 2	008 Jelsen							

OCME

	1 - State Registrar	Certificate of Death	Reg. No.	000 10/9
ysician /ledical	HNTHONY	ROHLSEN	2. Date of Death Month Day MAY 12	Year 2008 1414 M
aminer	40 English Name (If not institution also stands and supplied	4b. City, Town, or Location of Baltimore City rthday) If Under 1 Year I If Under 2		y of Death n/a 9. Birthplace (State or Foreign
eral ctor	109-64-2494 Usual Residence of Decedent	Yrs. Months Days Hours	Min. (Month, Day, Year) 9–2–1971	Country)
fed at	10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limit:
be notified	10e. Street and Number	nn Oak 10f. Zip-Code	10g. Citizen of	What Country?
any Injury or other traumatic event, the Medical Examiner must be notified a once. To Be Completed by Funeral Director	11.05 Harwall Road 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 No	21207 13. Was Decedent of Hispanic Original Mexican, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.) 14. Rad Bla	ce - American Indian, ack, White, etc.
cal Exam	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	a. Decedent's Usual Occupation (Give kind of work done during most)	16b. Kind of B	ity: African-American Business/Industry
t, the Medical E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	T Specialist	Bill Me	Later
tic event,	Farl Usher	Juani	's Name (First, Middle, Maiden Surna ta Bryant	
trauma		o. Mailing Address (<i>Street and Number</i> 611 Reserve Circle, Ap		
/ or other	20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place cemetr	of Disposition (Name of ery, crematory or other place)	Date 20c. Location	- City or Town, State
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ian	23a. Part 1. Enter the disease, or emplications that caused he death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Approximate Interval Between Onset and Death
s the burial-transit a second		of):		One Day
od for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death	n 3 Ectopic pregnancy 5 Other (specify)	1	ate of delivery onth Day Year
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page 2 should			24a. Was an autopsy performed?	. Were autopsy findings availab prior to completion of cause o death? 1 \sum Yes 2 \sum No
director,	examiner?	Other:	of Death (Check only one) ing Home 5 ☐ Residence 6 ☐ Ot	ther (Specify)
e =	07.14 (0.0)	Time of Injury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occu	rred
ed in by the funera	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
completely filled in by the fun Medical Certification				
E S	29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 9.30PM M RODRIGUEZ 05 2008 ALVARO 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death BELAIR HARFORD BELAIR MD LORIEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
03/24/1930 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days Mir 1**⊠**M 2□ F 212-36-9529 Yrs Peru Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 803 Cashew Court 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 □ No Specify 3 Widowed 4 Divorced Spanish Spanish 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Mathematician Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Isabella (nmn) Leon-Valardi Maximo Alvaro Rodriguez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Rodriguez / Wife 803 Cashew Court, BelAir, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Towson, Maryland Hilltop Service Corp. 5-13-08 21. Signature of Fun ral 5 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 → No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 40 26. Place Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

10a. State

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12 should be filed within 7 h and Mental Hygiene.
7 le marked other than "r

Health item 27

Pages 1 tment of 1 Department of Important: If it any injury or o one 0

permit.

Maryland 21215-0036

Baltimore,

Box (

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Records,

Division of Vital

death.

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Director:

within 24 hours after To the Funeral Dire

7 ie marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

/Medical

Examine certificate be executed burial-transit and attending physicien for use as the burial Physician/Medlcai detached the signed by I þ Completed peen has page certificate Be 2 this funeral Certification: After Attending

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 🗌 Yes 2 No 27. Manuar of Death 1 Natural

31. Date filed (Month, Day, Year) MAY 1 4 2008

2 Accident

3 Suicide

4 | Homicide

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1. Wertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

VW. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

completely filled in by the

Medical

Registrar's Signature

ND

08-03594 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Timothy Swann State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day May 11, 2008 Year 0239 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreian 27 Months Days Hours Director 18-96-2076 Country) Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits Town or Location 1 Yes 2 No 28a-f show more or other traumatic event, the Medical Examiner must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Directo 10g. Citizen of What Country 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. 1 Never Married Armed Forces 2 Married 2 X No Yes If Yes, Give Year or Dates: Yes 2 No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 over 18 Mother's Name (First, Middle, Maiden Surr 17_Eather's Name*(First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Tov .3 md 21229 20c. Location - City or Town, State 20b. Place of Disposition (Nam Baltimore, crematory or other place 2 X Burial Cremation 3 Baltimore Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name 23a. Part I. [In]er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Sharp Force Injuries of Neck and Shoulder Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes 2 No director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other: Inpatient 2 PER/Outpatient Nursing Home 5 Residence 6 After this 1 Yes funeral 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject stabbed/cut FOUND: Natural Yes 2 🗸 No Pending the To the Funeral Director: May 11, 2008 0226 hrs 2 Accident Investigation completely filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Unknown. determined (Specify) Other (specify) unknown 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 12, 2008 O.C.M.E. - IMD. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

31. Date filed (Month, Day, Year)

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ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND THE PROPERTY CSO 6/6/08 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) LEWIS 9 Day 200 8 **Physician** SORROW MAY 4:15AM ELTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Center-Columbia Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ₹ M 2 □ F 254-28-2914 85 Yrs. Director 1922 Georgia Nov 12 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State MD 10b. County Howard 10c. City, Town or Location Columbia 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1⊕ Yes 2□ No If Æes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mass Transit Authority Elementary/Secondary (0-12) College (1-4or 5+) secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Whitaker Sorrow Willie Florence Bryant 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myla Baker (daughter) 5827 Melville Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 5-14-08 Sykesville, MD any injury 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Daugh Hought Sterkert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Hoberoscle if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine asety Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Souple MD 00053150 8005 01 YAM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Sanhap Rd Suiteno suple MD

State Registrar

Shakunmale

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death SHEARER Month 0940 MRL M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Glen Burnie 7975 Crain Hwy S Apt 210 8. Date of Birth (Month, Day, Year) Sept 23, 192 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours 233-40-9603 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2XXNo Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21061 USA Apt 210 7975 Crain Hwy S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola June Hollis Richard H. Aikens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Snowden Lane, Glen Burnie, MD 21061 Daughter Barbara Jacobs 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State May 16, 2008 Glen Burnie, MD 4 Donation 5 Dother (Specify) Glen Haven Cemetery nati Funeral Service 22. Name and Address of Facility 21. Signat Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MON Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate and Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 25 ☐Other (Specify) 27 ccurred

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician as the l use for signed by the a d be detached f been : has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I

Division or Vital Records, P.O. Box 68760,

Physician/Medical ۵ Completed Be 2 Certification:

									24a. Was an autopsy performed?	
Was case referre	ed to medical						26. Place of Dea	ath (C	Check only one)	
examiner?	No	Ho	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 1	AOC	Other: 4 Nursing H	lome	Residence	3 [
Manner of Death Natural Accident	5 ☐ Pending investigation	1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М		Injury at Work? 1 ☐ Yes 2 ☐ No	280	d. Describe how injury	ус
3□ Suicide	6 ☐ Could not b	е	29a Blace of injury At h	omo form otro	at foot	001.0	Hino	006	f Loopting /Ctroot on	

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier

Medical

3 Suicide

4 Homicide

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

determined

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of death (Item 23a) (Type, Print) CHAEL 445 EFENSE HIGHWAY

State Registrar 31. Date filed (Month, Day, Year) Registrar's Signature

14 2008 MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 300g **Physician** HARLES EDMOND TELEWICZ 340 AM MAY 117 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 103 SOUTH HIGHLAND AVENUE BALTIMONE CITY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 ☐ F Days Hours 220-38-6993 MARYLAND Director 66 MARCH 13, 1942 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 MYes 2 □ No Director BALTIMORE MD BALTIMORE CITY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 103 SOUTH HIGHLAND AVENUE 21224 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Iten Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗹 No Baltimore, Maryland 21215-0036 Specify: WHITE 2 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OFFICER SECURITY SECURITY 19 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be 1 Mental if Health and Mental EDMOND TELEWICZ CATHERINE MORGERETH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HANKS/DAUGHTER HIGHWAY FARNHAM VA 22460 HISTORYLAND Pamela 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of h
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ARDENT USEMATORY MAY 14, 2008 MANOUAR 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility ARDENT CREMATIONS 7532 CONVELLEY DZ HANDUR IND 31076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physiclan** UNG CANCER months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit the death certificate be exec Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 Probably 4 Unknown 2 No certificate has been s' rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

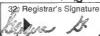
1 Yes 2 No Division or Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident To the Hospina
within 24 hours after death.
To the Funeral Director: Aft М 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifler Medical and manner stated.

State Registrar

R. ANANDA KRIBHNAN 821 N. EUTAW ST #305 BALTIMONE MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

129071

29d. Date signed (Month, Day, Year)

			For State Registrar	State	of Marylar		artmen <i>tificat</i>			nd M		giene Reg. No.	2008	1581	00
	*	п	Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ath Day	Year	3. Time of De	ath
ļ.	Physicia Medic	_	Louis Thornto	h							May	S	2008	7=52	PM
0	Examin		4a. Facility Name (If not institution,	give street and nu					Location of	Death	1	4c.	County of Dea	th	
			Johns Hopkins Ba	friew Med	lical Cer	ater	-		nore						
	Funeral		5. Social Security Number	6. Sex 1⊠ M 2□ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day	h v, Ye <i>ar)</i>	9. Bir	thplace (State or Fo ountry)	oreign
Sec.	Director		220-50-4032	1 Z 1 V 2 _ 1	57	Yrs.					09/10/1	950		MD	
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City L	_imits
	faryli sho ed at	ō			_									1 ☐ Yes 2	X No
	the N 28a-1 Potifii	Director	MD Baltin 10e. Street and Number	ore	Du	ndalk_	10f. Zig	Code				10a. Citi	zen of What C	ountry?	
	with 3a or t be I											,	TC 70	•	
	heath ns 23 mus	Funeral	28 Patapsco Ave	12. Was Dec	edent Ever in U	J.S. 13. 1	Vas Dece	222 dent of Hi	spanic Orig	in? (Spe	cify Yes or No-		JSA 14. Race - Am		
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Ö	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	Year or I	^{ive} ^{Dates:} Viet	nam	1 ☐ Yes	21 X No	Specify:				Specify: W	hite	
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Maryland 21215-003	ar is		19a. Informant's Name/Relationsh				•				l Route Numbe			zip Code)	
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-	Physician /Medical		disease or condition resulting in death)		(or as a consec		ilure							1 hour	
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Vital Records,	uires sign Id be	d by									101	Yes 2	□No 3□F	robably 4 Donk	nown
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Division or	r Atte	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 200. Flat	e of injury - At h	nome, farm, sti	eet, factor	y, office		2	28f. Location (5 City or Tov			lural Route Numbe	ľ,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical		g Physician: To the Examiner: On the	basis of examin										
	thin 2	Med	29b. Signature and title of certifier	and ma	nner stated.		29	c. Licensi	e number			29d. Da	te signed (Mor	th, Day, Year)	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** \mathbf{P}^{M} 3, 2008 Morris Tyler Mav 4:55 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Nursing Home St. Mary's Charlotte Hall If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 2, 19 Birthplace (State or Foreign Country)
 CT 6. Sev 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1**X**□M 2□F 040-16-5227 95 1912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1 ☐ Yes 2 No Director MA Plymouth Norwell 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or dical Examiner must be r 1044 Main Street 02061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. within 72 hours after 1 XYes 2 No 1941 If Yes, Give 1941 Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ≥ 3X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Analyst Manufacturing marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Robert Tyler Inez G. Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Tyler (Son) 19704 Golden Valley La., Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place)
Massachusetts 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State May 8, 2008 National Cemetery Bourne, MA 21. Signature of Funeral Service Licens 22 Name and Address of Facility
Sullivan Funeral Home ennes 551 Washington St., Hanover, MA 02339 Manne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARKINISONS DISEASE Physician YRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9∏Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe Division or Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 7003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Stephen Cafferty, MD 22333 Greenview Parkway Great Mills, Maryland

Registrar

State

31. Date filed (Month, Day,

gistrar's Signature

2008

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** Nen 2008 10 mai /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner hanch made Court Ellicott Cita Howard If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Days 9269 JANUARY 3 1921 NEW YORK Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No MD SAWOH by Funeral Director COLUMBIA 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21044 SLACK USA LANG 12. Was Decedent Ever in U.S. Armed Forces? 1 154 Yes 2 □ No if Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 'natural", or Specify Specify: WHITE 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) TRAUEL TRAVEL ALGENT 19 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 MARGUERITE FRANK UERIT (RODSIL 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARCHINEDE COURT ELLICOTT CITY MD 21042 CAROUNE CRISCUOLI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANDTONY WIFTS NEWSTRY MAY 14, DOUB MANOUN 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7522 LONGELLEY DR. HANDVIR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNLL MONIA **Physician** ASDIRATION /Medical (or as a consequence of): Examiner Due to (or as a consequence of month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed attending physician and for use as the burial-trans-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year John Vogel JR. 5:45 PM 75 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death sedale Itimore Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 5. Social Security Number 217–16–1325 1 □XM 2 □ F Months Davs Hours Min 18,1917 Director 91 March MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f shoviner aust be notified at MD Baltimore Nottingham Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4527 A Ridge Road 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No þ Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Time Keeper Beth Steel 12th 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental H item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be John Vogel Sr. Edna Mae Brown injury or other traumatic မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Spalding /daughter 4527 A Ridge Road Nottingham MD 21236 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specific) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bayview Crematory 5/12/08 Baltimore MD Funeral Service Licens 21. Signa in 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 Part : Effer the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any leading the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-tran and Due to (or as a consequence of) the attending physician hed for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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Box 68760. 0 ۵. Division of Vital Records, To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

D0055034 2008 ess of person who completed cause of death (Item 23a) (Type, Print) Mes 4000 31. Date filed (Month, Day, Year) MAY 14 2008 State Registrar

29c. License number

29d. Date signed (Month, Day, Year,

29b. Signature and title of certifier

and manner stated.

DHMH 17 Rev 1/2001

Registrar

MAY 14

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Cass mark Kathleen John Wallace 2005 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-6-1949 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1□M XX 219-50-0514 59 MD Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Mη N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 3221 Avon Avenue 21218 S Α Funeral . Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Black 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Dulaney Eye Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Eye 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cummings John Lillabell Epps ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricardo R. Wallace -Husband 3221 Avon Avenue Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐Removal from State 5-13-2008 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) March F/H East 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 la O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ule Immediate Cause (Final Physician Ca disease or condition resulting in death) wus /Medical Due to (or as a consequence of) Examiner RC 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 0 and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe es 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ER/Outpatient Certification: To 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Notural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal

Division or Vital Records, P.O. Box 68760, within 24 hours a'

> State Registrar

(Check only

29b. Signature and to

31. Date filed (Month, Day,

and address of person who completed

DHMH 17 Rev 1/2001

32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

and manner stated

al

29c. License numbe

29d. Date signed (Month, Day, Year)

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State Registrar

05 09 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2008 MAY 6, 6:00 PM SYLVIA WHITE LELIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S BRADFORD OAKS NURSING & REHAB CLINTON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🗶 F Yrs. 23, 1923 AQUASCO, MO Director 85 578-38-9222 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1XYes 2 No Director Washington DC 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20020 USA 2016 Ft. Davis Street, SE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No Specify: Specify: 3 Widowed 4 □ Divorced 2 Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cryptanalyst NSA 4 yrs. 12 should be filed v h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If item 27 is marked of any Injury or other traumatic ew Lelia V. Hughes Rufus Sylvester Reid 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Reid / Son 125 Riverside Dr. #3F New York, NY 10024-3710 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 05-13-2008 Lincoln Memorial Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD 23a. Padi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Years ATHEROSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2XNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō e Funeral filled 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar FRANK

RYAN

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

D19431

11711 LIVINGSTON ROAD STE 103 FORT WASHINGTON, MD

May 8, 2008

MD

32. Registrar's Signature

Stallet 3.1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 11:40 A^M May 2008 Wayland Wayne Wolford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 8036 Clark Station Road Severn 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1**X** M 2□ F Months Days Min. Yrs. Maryland Director 10-30-1946 217-46-2925 61 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Experience must be notified at 1 ☐Yes 2X No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 8036 Clark Station Road United States 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, I'm Media. Elementary/Secondary (0-12) College (1-4or 5+) Trucking 11 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter W. Wolford, Sr. ပ္ Doris Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Cecilia M. Wolford / Wife</u> 8036 Clark Station Road Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arundel Crematory 05-14-2008 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Rure of Funeral Service Licensee M01522 1411 Annapolis Road Odenton, Maryland 21113 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that cause 4 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) to **Physician** からかかとい /Medical Due to (or as a conservence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Exami signed by the attending physician and I be detached for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 INO 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 XNo 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P eral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1241 30. Name and address of person, who completed cause death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) istrar's Signature State 2008 Registrar MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5&11 &19a&b Per INF G881 //17/08 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** RONALI 0220 M APRIL 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hopkins Bayview Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Numberunk 6. Sex 8. Date of Birth (Month, Day, Year)
Jan 1, 1937 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min unk 212-34-3113 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at MD 1 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1501 Elrino Street 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: White Specify by Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) unk unk 7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hopkins Bayview Hospital **Vicky White** 47501 EIFING STREET Baltimore, MD item 27 i other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state Director 21. Signature of Funeral Service Lice see 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 enn Approximate
Interval Between
Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Artherusclevotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FÉMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant In the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Completed by Emphysema 3 Probably 4 □Unknown 2 🗌 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page certificate 1□ Yes 2 XNo director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury within 24 hours aner control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. Diallo 5505 Hopkins Bayview Circle (EMERGERLY NOON) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 4 2008 Registrar

				per verb	2879,05/1 Tillicate of	Death Death	, 	3	18 1281
Physic /Med		Decedent's Name (First, Middle, Last Samuel Zager	") 				2. Date of Dea Month April 2	Day	3. Time of Death 5:00 PM
Funeral		4a. Facility Name (If not institution, give 26 Arthur Drive E 5. Social Security Number 6. Se		(In yrs. last birthday) 86 Yrs.	4b. City, Town, o Fort Was If Under 1 Year Months Days	hington If Under 24 Hrs. Hours Min.	8. Date of Birt	th v Year	ce George's 9. Birthplace (State or Foreig
Director Monda Mon		5 / / -6U-6U19 Usual Residence of Decedent 10a. State		10c. City, Town or Lo			June 6	, 1921	10d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturef", or itema 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be inclined at anne.	al Director	MD Anne Aru 10e. Street and Number 4935 Kellam Road	indel	Shady	101. Zip Code 20764			10g. Citizen of Wh	1 ☐ Yes 2√ No
ours after dea	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 21 No	ispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	. 14. Race Black, Specify:	- American Indian, White, etc. White
Mica y failed within 72 hours af d 2 should be filed within 72 hours af th and Mental Hygiene. 7 le marked other than "naturef", or treumatic event, the Medical Exami	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5-	+) (Give	dent's Usual Dccup kind of work done of DO NOT use retired hotograpl	during most of work i)	ing	16b. Kind of Busi	
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is 1 and 2 short Health and Item 27 to n		19a. Informant's Name/Relationship (T) Gary Zager/son 20a. Method of Disposition	,	26 A	rthur E H	Fort Wash		•	.4
permit. Pages 1 ar Department of Hea Important: if Item any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☒ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Services licens					d 655 W	. Baltimo	ore Street
Physician /Medical Examiner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Chronic	the death. Do not enti	altimore or the mode of dyin twe Pu	g, such as cardiac of	or respiratory are	rest,	Approximate Interval Between Onset and Death
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Phys this aldi	ToB	examiner? 1	lospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 Nursing Ho	me 5 Pes id	- (
To the Hospital or Attending within 24 hours after death to the Funerel Director: After completely filled in by the funer	il Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc.				City or Town	n, State)	or Rural Route Number,
To the Hos vithin 24 ho To the Fun completely i	Medical	(Check only one) 29b. Signature and title of certifier	ner: On the basis of eand manner state	my knowledge death examination and/or inved.	estigation, in my op	inion, death occurr	ed at the time, d	date and place, and 29d. Date signed (d due to the cause(s)
		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type F		38563	3 /	to 130.	2007
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	Examir	er	4a. Facility Name (If not institution, g	ive street and number)), =		4b. City, T	1	Location (ムーリ	of Death			County of De		<i>(</i> 2)	
	Funeral		5. Social Security Number 6.		In yrs. las	t birthday)	If Under 1	Year	If Under		8. Date of Bir (Month, Da	rth	9. B	irthplac	ce (State or For	e <i>ign</i>
	Director		408-36-1157	1□ M 2 ∏ F 8	8	Yrs.	Months	Days	Hours	Min.	12/9/1				ssee	
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ett 215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	er in U.S.		Vas Decede Yes, speci □Yes 2		spanic Ori n, Mexical Specify:	igin? (Spec n, Puerto F	cify Yes or No Rican, etc.)	D-	14. Race - An Black, Wh Specify:			
F-0-5	72 ho 'natur dical	eted	15. Decedent's (Specify only highest of		Į.	16a. Deced	ent's Usual kind of work OO NOT use	Occupa	tion uring mos	t of workin	a	16b. F	(ind of Busines	s/Indus	stry	
	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			oo not use naker	retired))			ا م	omestic			
and 2	i filed I Hygi other ent, t	Be C	17. Father's Name (First, Middle, La	st)	I	TIOINCI	iidisc L		18. Mothe	er's Name	(First, Middle				-	
Be	should be ind Mental marked o	To B	Frank Freeman						Mag	ggie	Tipton					
Mar	and 2 sho ealth and n 27 is mi er trauma		19a. Informant's Name/Relationship Norma Jean Hepn	1 71			g Address (_				_	or Town, State			
ഡ વા વવ Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3	Unemoval nom State	20b. Plac		sition (Name natory or oth		9)	Da	ate	20c. L	ocation - City o	or Town	n, State	
त् 	permit. Pages Department of Important: If it any injury or c		4 □ Donation 5 □ Other (Special Signature of Funeral Service In		Jeru		Ceme			5/2/0			rsonsbu			
ંક હ —	permit. Departn Importa any inju	y y	· WRNel	lun dF:	SP	5	01 Sn	ow F	Hill	Rd.,	Salisk	oury	, MD 21	Ass .804	ociatio	'n
			23a. Part1. Enter the disease, or co shock, or heart failure. List on											- Ir	pproximate nterval Between Inset and Death)
	Physician /Medical	îi	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c			4	EA	70		TAG	12		1		
	Examiner					100 N	iA									
	p #	iner	Sequentially list conditions, it any, leading to in rectate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as e.c.	roneaquer	O OF										
	and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onsequen	ice of):								-	-	
38760,	cate be executed physician and the burial-transit	dical		d												
•		Medi	IF FEMALE:													
P.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as is	Physician/Me	23b. Was decedent pregnant in the past 12 ments? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal de	eath 3 🗌	Ectopic pre Other (spe						23d. Date of d Month		ay Year	
ords, P	w requires that been signed k should be deta	by	Part II. Other significant conditions	contributing to death but r	not resultir	ng in the un	derlying cau	use give	n in Part I				0	to the Probab	cause of death oly 4 □Unkno	
Division or Vital Records,		Completed									24a. Was auto perfi 1∐ Yes	an psy ormed? 2	_ death	?	y findings avail letion of cause ☑No	able of
Vit.	Physiclan: this certificatal director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	۰۵۰۰	· · · · · · · · · · · · · · · · · · ·	a= po+	Otho	r.		(Check only		A STATE			
0.	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28	Outpatient		c. Injury Work	4 🗆 N(8d. Describe		6 □Other (S _I	pecify)		
sior	Attending or death. ector: Afte by the fune	atio	Datural 5 Pending investigati		ear)	Injury	М		/es 2 □	No						
Divis	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not determine		- At home 'Specify)	e, farm, stre	et, factory,	office		2	8f. Location (City or To	Street a wn, Stai	nd Number or 'e)	Rural f	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) Certifying F	Physician: To the best of r aminer: On the basis of ex and manner stated	kamınatıor	edge, death and/or inv	occurred a estigation, i	t the tim in my op	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the	cause(s) and manner nd place, and d	as stat lue to ti	ed. ne cause(s)	
	To the within 2. To the complet	Σ	29b. Signature and title of certifier				29c.	License	number	UIA		29d. Da	ate signed (Mo	nth, Da	ay, Year)	
	250		30. Name and address of person wh	o completed cause of deat	h (Item 23	Ba) (Type, F	Print)	טטעו	3 8	7/ 0			1/26/	0)	8	
	d		EHULAM WARIS	COASTAL	Hos	PICE	Po	130	×17.	33 (sattis	BULL	y no	2	1202	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 0 1	o completed cause of deat COASTAL 32. Figistrar's	s signature	A	ande									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BEN BENSAEID APRIL 25, 2008 3:02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1236 HILLTOP DRIVE ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F JULY 4, 70 1937 **IRAN** Director 225-27-0102 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural" --- " any injury or other traumatic every "..." 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1236 HILLTOP DRIVE 21409 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE b 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 EXECUTIVE CHEF HOTEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHAMIM BENSAEID FAREYEH BENSAEID ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1236 HILLTOP DRIVE, ANNAPOLIS, MARYLAND 21409 SHAMSI BENSAEID/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State APRIL 29 ANNAPOLIS, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 M00672 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MES 17HELDUA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Gusease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed J physician and as the burial-trans Due to (or as a consequence of): .O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Division or Vital Records, P. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Š 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature 30 Name and 15

State Registrar

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31. Date filed

Bay,

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Year)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 3:40 CATHERINE M. BEREZNE 2008 6 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March Day 1928 Social Security Number 219–20–7965 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Maryland 80 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at York Delta 1 ☐ Yes 2\times No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 17314 276 Ailes Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2**%**No Maryland 21215-0036 1 ☐ Yes 2 █XNo Specify: Specify White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kemmer Anna Zipp ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17314 Denise C. Melpignano/Daughter 276 Ailes Road, Delta, PA Baltimore, 20a. Method of Disposition
1 ☐Burial 2 ☐Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐ Removal from State St. Stanislaus Cem. 5/9/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 600 Main Street 22. Name and Address of Facility 21. Signature of Funeral Service Lice Harkins Funeral Home, Inc., Delta, PA art 1.2 h or the dise e, or com, tations that caused the dead Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∐ Yes Division or Vital Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ M 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cusin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Zubair Kharal

14 2008

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

m. D. 500 Upper Chesapeake Dr. Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. C. UU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Edith Louise Ryman Crue 2008 161 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DIPO 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Aug. 13, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1934 Maryland 212.32.0699 1 M 2 T 73 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shoved at Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9085 Fox Meadow Lane 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: φ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Administrative Assistant 12 Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Franklin T. Ryman Naomi Bender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Harry M. Crue/Spouse 9085 Fox Meadow Lane, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCenter 5.11.2008 Cambridge, Maryland Mid Shore Cremation Center, PO Box 1464, 2272 Hudson Rd., Cambridge, MD 21613 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) -une cure /Medical Due to (or a a consequence of): Examiner vacco Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that in its lead of the cause). Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buris certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) P.O. 2.□No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ anenmony to 1 ☑√es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has this certificate 065K ease 1□ Yes 2√√No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2√1No Hospital: Other: 4 \(\subseteq \text{Nursing Home} \) MInpatient 2 ER/Outpatient 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: or Attending Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 29b. Signature and title of certifier

w.

Year)

AUL

219 S. Washington St.

29d. Date signed (Month, Day, Year)

Easton, MD

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Charles Davis Sr. 2:55 04 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Coastal the Lake Salisbur 1 aspice Wicomico 5. Social Security Number 6. Sex If Under 1 Year | Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Min. 1 **M**M 2 □ F 220-26-8699 Director 5/1/1932 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d, Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 704 Hammond St. 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Nover $(\mu \nu_i)_S$ Sr Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk food store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Davis Gladys Quillen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Hammond St., Salisbury, MD 21804 Betty Jean Davis/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 4/30/08 Salisbury, MD 21. Signature of Funeral Service License 22 Holloway Funeral Home Professional Association Kerlo K 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician METATATIC PANCERATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical ase If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ No certificate has page 2 autopsy performe 1[20 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 | Yes Æ No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20058410 4-28-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 1733 Stais BURY up 21802 CHUMM WARG OASTAL

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State

Registrar

31. Date filed (Month, Day, Year)

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	1 State Registrar	Certificate of Dea	ath R	eg. No 2 U U 0 1 5 0 1 /
Dharatatan	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th 3. Time of Death Day Year
Physician /Medical	KENNETH E. DETWILER		04/28/	
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca		4c. County of Death
	Hartley Hall Nursing Home	Pocomoke	City	Worcester
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs	Months Days Hou	nder 24 Hrs. 8. Date of Birth urs Min. (Month, Day,	Year) 9. Birthplace (State or Foreign
Director	220-09-1546 ^{1MM 2□F} 91	Yrs.	urs Min. 10/12/	1916 Michigan
pu ,	Usual Residence of Decedent	ity, Town or Location		40d traids City Limits
aryla shov dat				10d. Inside City Limits 1√□ Yes 2 □ No
8a-f ptifie		omoke City		
vith the Mar s or 28a-f sl be notified Director	10e. Street and Number	10f. Zip Code] 1	0g. Citizen of What Country?
ath v	1006 Market Street	21851		USA
r items 23c	11. Marital Status 12. Was Decedent Ever in Under Armed Forces?	J.S. 13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Jus after all, or in year Inc.	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 3 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 🎾 No Spe	ecify:	Specify:White
filed within 72 hours after death with the Maryland Hygiene. Hygiene, Hygie		16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
ed within 72 hor ygiene. ner than "natur. t, the Medical E	15. Decedent's Education (Specify only highest grade completed)	(Give kind of work done during life. DD NDT use retired)	most of working	Tob. Kind of business/industry
withi withi ene. than the M	Elementary/Secondary (0-12) College (1-4or 5+)	Contractor		Construction
Hygir Hygir	17. Father's Name (First, Middle, Last)		Mother's Name (First, Middle, I	
d be filed by the control of the con	Menno Detwiler		die Sharp	,
2 should be and Mental Is marked o aumatic eve	19a, Informant's Name/Relationship (Type. Print)			; City or Town, State, Zip Code) 21851
id 2 s id 2 s ith ar trau	Gerald K. Detwiler/ Son	1628 Cedar Hal		
1 and Health Health tem 27	20a Method of Disposition 20b.	Place of Disposition (Name of		20c. Location - City or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. When the Mental Hygiene with an and Mental Hygiene with an and Inferest and Inferest and Inferest and Inferest and Inferest and Inferest I	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	y Grove Memonite	i	Westover, MD
iit. P artme ortan Injur	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	•		
Depa Impo any It	M. K. A. Dean	Holloway Fun	eral Home, P.7	ty, MD 21851 A. 103 Linden Ave.
	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause or peach line.	th. Do not enter the mode of dying, suc	ch as cardiac or respiratory arro	est, Approximate
Physician	Immediate Cause (Final			Interval Between Onset and Death
/Medical	disease or condition resulting in death) a. Due to (or as a conservation)		ease	10-90
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<u>ه</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	quence of):		
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al-tra	that initiated events c	quence of):		
certificate be ding physici se as the bu	V.			
	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant			23d. Date of delivery
nat the death d by the atter etached for u	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No			Month Day Year
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res that the death igned by the attenbe detached for ub detached for uby Physician	Part II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in F	Part I. 23e. Did tot	pacco use contribute to the cause of death?
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ne lav has ge 2			autops	prior to completion of cause of
siclan: Th certificate rector, pag			1 Yes	2 MNo 1 LIYes 2 LINo
sician: The certificate harector, page	25. Was case referred to medical examiner? Hospital: Hospital:	Other	Place of Death (Check only on	
Hospital or Attending Physician: The law requires that the death Funeral Director: After this certificate has been signed by the atter tely filled in by the funeral director, page 2 should be detached for used I certification: To Be Completed by Physician	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	JEH/Outpatient 3LJDOA 4	Nursing Home 5 Reside	ence 6 Other (Specify) ow injury occurred
ital or Attending R is after death. ral Director: After led in by the funer. Certification:	1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury at Work? M 1 ☐ Yes		ow injury occurred
ttend death stor: / the	3 Suicide 6 Could not be 390 Blace of injury 4th	nome, farm, street, factory, office		reet and Number or Rural Route Number,
or A after Direction by	4 Homicide determined building, etc. (Speci	ify)	City or Town	n, State)
pital burs aurs a filled	29a. Certifier 1 Certifying Physician: To the best of my kn	awladge death coourad at the time de	ate and place, and due to the e	augusta) and manner as stated
Hos 24 ho Fun stely	(Check only one) Check only one Check one Check only one Check on			
To the Hospital or Attending Physical Milhin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral difference of the funeral differen	29b. Signature and title electrifiel	29c. License num	nber 2	9d. Date signed (Month, Day, Year)
E 3 E 8	Jon my	7 ~ 11	1.25	4-28-08
	SARAD R. BARA	- CO \ (T D : -)	166	7-28-00
BA 3	30. Name and address of person who completed cause of death (Itel	m 23a) (Type, Print)	D 21851	
10110	31. Date filed (Month, Day, Year) 32. Registrar's Sign		/ 0103/	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** mond May 2008 120 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1timore Bayview Medical Center Johns 110 BALTIMORE CITY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Months Min Director 146-14-0815 85 9-13-1922 NEW **JERSEY** Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ¾☐ No MD. CHARLES Director LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 11969 LINCOLN DRIVE 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. Yes 2 No NAVY ryes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 Widowed 4 Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Item 27 is marked other than "natu other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) AIRCRAFT PARTS College (1-4or 5+) Elementary/Secondary (0-12) CHIEF ENGINEER CORP 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental tem 27 is marked or should be RAYMOND S.DENNISTON, SR. ELEANOR GILLILAND ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION B.DENNISTON-SPOUSE 11969 LINCOLN DR. LA PLATA, MD. 20646 Pages 1 and Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages is Department of HIMPortant: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT.REST CEMETERY 5-14-08 LA PLATA, MD. 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. PLATA, MD. 20646 LA23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** minule /Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 4. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 No 1∐ Yes Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3∏ DOA Certification: To this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

OX

of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

0

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

"Ave Suit 204 Cumber Land MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Macen

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31. Date filed Worth

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Fowler Elizabeth Ann 27, 2008 4:15 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Wicomico 501 Elberta Ave. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 👿 F 82 220-12-1176 Director 11/1/1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "naturat", or items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits 10h County an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 1 XYes 2 No Wicomico Salisbury Maryland Director 10e. Street and Number 10g. Citizen of What Country? 21801 501 Elberta Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2**X** No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. white ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madge Wallace Austin L. Mills injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
501 Elberta Ave., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type, Print) Delbert E. Fowler/husband Department of Health Important: If item 27 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Wicomico Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park 22. Name and Address of Facility
Holloway Funeral Home Professional Association of Funeral Service Licens 501 Snow Hill Rd., Salisbury, MD 21804 Part, Enter the disease, or complications thus aused to sinck, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, romediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANOEXIA 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▶ No 24a. Was an autopsy performed? 2 X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death. after death filled in by the To the Funeral

29a. Certifier (Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAWS 10120 31. Date filed (Month, Day, 2008

MN

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended item#19a.45/1/08, WCHD, SLU Certificate of Death

Reg. No. Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL SALISBUM VICOMICO MEDICAL CENTEX 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 2 -906 Director Maryland 4-13-1930 -26 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 518 items 23a 111 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced "natural" er than "nature, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kinehurst Education 2 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ^{19a}SYTVTA^NHaRelis/HaUghtet 681 Hideaway Dr. 27 Parson burg MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State John Wesley -4-08 Mardela Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) eral Service 22. Name and Address of Facility 21 Se 917 W. Isabella Salisbury 3xnni < Smith truneral Home 0816 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death gastrountes tina **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner multiple Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 🗌 Yes 2 No within 24 hours after death. To the Funeral Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of equifier 29d. Date signed (Month, Day, Year)

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220-26-9067

MARCH

State Registrar filed (Mouth Pay, Year) 32. gistrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Egistrar's Signature

Peninsula Regional Medical Center

State of Maryland / Department of Health and Mental Hygien [] Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Violet Marie Farmer 7:25 Ам April 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 2607 Old Ocean City Road Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 2 SE 216-56-2432 Director MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location r then "neturel", or Items 23e or 28e-f show 10d. Inside City Limits MD Wicomico Salisbury Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2607 Old Ocean City Road 21801 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Interest if item 27 is marked other then "neturel; or Ite inty or other treumatic event, its Maddial Engine in yor other treumatic event, its Maddial Engine. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Land Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashieda L. Farmer/daughter 2607 Old Ocean City Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cem 5/03/2008 Berlin, MD 21. Signature of Euroral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cervica Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, begins to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burla Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 gronths?
1 2 Yes 2 2 70 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 XN0 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 25 No 255 No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Stresidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28c. Injury at Work? 28b. Time of 28d. escribe how injury occurred After : Hospitel or Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130x (OASTAL 31. Date filed (Month, Day, Year) HOSPILE 2. Registrar's Signature State Registrar MAY 0 1 2008

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 0 8 5 8 2 0									
	1. Decedent's Name (First, Middle, Last)						Certificate of Death			2. Date of Death 3. Time of Death		
	Physic		Marquerite Reattie Folsom							Day Yes 26 200	ar	
	/Medi Examii		4a. Facility Name (If not institution				4b. City, Town, o	r Location of De	April	4c. County of D		
	LAUIIII		Holy Cro	oss Hospital	1			lver Spri			gomery	
	Funeral		5. Social Security Number	6. Sex	Sex 7. Age (In yrs. last birthday		If Under 1 Year If Under 24 Hrs.		Irs. 8. Date of Bi	rth 9	9 Birthplace (State or Foreign	
ш	Director		026-16-0512	1 ☐ M 2 🖾 F	8	36 Yrs.	Months Days	Hours M		5, 1921	Vermont	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of Decedent 10a. State 10b. Count		100	City Town or Lo	ecation				10d. Inside City Limits	
		ō								1 ☐ Yes 2 ☑ No		
		Director	Maryland Mo		Silver Sprin				10a. Citizen of What			
		Ö			Tot. Zip Code			0	,			
		Funeral	139 Claybı		cedent Ever in	nt Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.				U.S	• A • merican Indian,	
(0			1 ☐ Never Married 2 ☐ Ma	Armed I	1 ☐ Yes 2 🖾 No		13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican 1 □ Yes 2 ☑ No Specify:			Black, W	Black, White, etc.	
21215-0036		b	3 X Widowed 4 ☐ Divorce	d Year or						Specify: White		
5-0		Completed	15. Decede (Specify only highe	nt's Education est grade completed	1)	16a. Decedent's Usual Occu (Give kind of work done			e during most of working		16b. Kind of Business/Industry	
21	rithin ne. han "	ď	Elementary/Secondary (0-12)	DO NOT use retired)								
2	d 2 should be filed within: th and Mental Hygiene. 7 Is marked other than " traumatic event, the Mec	S	17. Father's Name (First, Middle		+		Homem		1 (F) 1.45 1.11	L	estic	
Maryland	the factorial Head of others	Be	,	,				18. Mother's Name (First, Middle, M				
Ĕ	hould d Me mark matic	P.	Henry Dougla		1	10h Mailir	na Addrona (Stroot		dith Jane 1	Beattie Der, City or Town, Stat	7-0-4-1	
Ma	d 2 sl th an 7 Is r traur		Kristina J. Fols	, , , , ,	laughtor					•		
	Heal Heal tem 2		20a. Method of Disposition	SOM GLANUC		b. Place of Dispo	sition (Name of		Date	, Maryland 20 20c. Location - City		
<u>0</u>	Pages ment of H ant: If ite ury or of	,	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (natory or other plac	i i	100 10000			
Baltimore,	nit. Parante ortant		21. Signature of Funeral Service		110	22	aven Cemete 2. Name and Addre	ss of Facility	/02/2008		ng, Maryland	
m	permir Depar Impor any Ir once,		Nancey A	Vence			ines-Rinale 1800 New Ha	di Funera ampshire	1 Home, Ind Avenue, Sil	ver Spring.	Marvland 20904	
E	Physician /Medical Examiner buyaician and sthe purial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
		7.4	Immediate Cause (Final disease or condition	a Seps							Onset and Death Days	
			resulting in death)	ci.	Due to (or as a consequence of):						Days	
4.			Sequentially list conditions.		b. Urinary Tract Infection Da							
		ine	Sequentially list conditions, if any, leading to immediate Cause. Et al. U. Janying Cause (Disease or injury	Due to	Due to (or as a consequence of):							
		xam	that initiated events resulting in death) Last	0.	rrhagic		Weeks					
68760,		dical Examiner		Due ii	Due to (or as a consequence of):							
687				d								
Box	n certi nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					23d. Date of	delivery	
m	that the death certifined by the attending professions of the detached for use as	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pre						Month Day Year		
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ord	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edt	Diarrhea 1 Yes 2 No 3 Proba							Probably 4 Unknown		
Records,		Completed	Diabetes Mellitus						24a. Was	as an 24b. Were autopsy findings available		
<u>m</u>		mo.	Diabetes Mellitus 24a. Was an autopsy performed? 1□ Yes 2☒ No 24b. Were autopsy findings availal prior to completion of cause of death? 1□ Yes 2☒ No							ic completion of cause of in: les 2 No		
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or V		은	1 Yes 2 No	Hospital: 1 🛭	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
n C		ü	27. Manner of Death 1 X Natural 5 ☐ Pendii	/4.4-	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			Work?		28d. Describe how injury occurred		
<u>s</u> i		cati	2 Accident investi	gation								
Division		Certification:	4 Homicide determ	nined 28e. Plac	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	ipital or curs afte leral Dir filled in											
	Hos 24 hc 24 hc Fun etely	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of certifier				29c. License number			29d. Date signed (Month, Day, Year)		
			192110	11/								
	20	-	D32332 0. Jame and address of person who completed cause of death (Item 23a) (Type, Print)							April 27, 2008		
			Suresh K. Gupta		,		,	, Silver	Spring. Ma	ryland 20902		
	Sta	te	31. Date filed (Month, Day, Year,		Registrar's Sig		Park .		, 0, -10			
	Registr	ar	WLU 9	0 2000	MAN COM	15. 1	JANA J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN TITM 26. per VERB 0879 5/14/08 WS
State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** RODGER ERNEST LEE HAINES MAY 8, 2008 2:02P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1⊠M 2□F 212-24-5068 79 Director Maryland June 6, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits be notified 1 ☐ Yes 2 ☑ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1088 Carlton Place, Apartment 1A 21703 United States "natural", or items 23a edical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1051 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Yes 2 No 1951-If Yes, Give Year or Dates: 1953 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Horse Groomer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Victor Haines, Sr. Eva Viola Gift 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Muhlen / Daughter 1088 Carlton Place, Apartment 1A, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory May 10, 2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Se M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 18 cavillal ustant Heale disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner COVONG JULY YEARS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2☐No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 1 Tes 2 No Other: 4 dursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 KER/Outpatient 3 DOA 1 ☐ Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Physician: The law requires that the death certificate be executed P.O. Box 68760, 江 physician as 1 attending use jo ed by the a detached f sate has been signed page 2 should be det Division or Vital Records, certificate has funeral director, After this the Hospital or Attending death 24 hours after death e Funeral Director: filled in by within 24

28a-f show

or items 23a death v

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filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

NYU

Day, Year)

4

31. Date filed (Month)

22037

5/8/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar amend #18&19a&b Per FH G879 6 14 14 108 eJH Death 582 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Barbara W. Humphries 2008 /Medical May 7:00P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Brightview Assisted Living Bel Air If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Funeral Social Security Number 6 Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2√2 F Director 226-56-8217 Usual Residence of Decedent 94 November2,1913WestVirginia the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show must be notified at 1X Yes 2 □ No Director Norfolk Chesapeake Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö items 23a 23322 729 Mount Pleasant Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23 Completed by Funeral <u>SA</u> 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: 3 Widowed 4 ☐ Divorced White other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chesapeake Secretary 12 Fire Department event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic ever Joseph Wood ၉ Mary Frances Fannie 19a Informant's Name/Relationship (Type Print)
John W. Humphries/son
Pat Humphries 19b Mailing Address (Street and Number or Rural Route Num 29) London Court Ruckersvi 1117 Windy Branch Way Fo ther City or Town, State, Zip Coor 968 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Riverside Cemetery 5-9-08 Norfolk,Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel Road, Baltimore, Maryland21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequ¹ ce of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) A 1 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) al or Attending Ph safter death. 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DOVID

31. Date filed (Month, Day, Year)

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MAY 1 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W.MA-PLA.

Registrar's Signature

D32275

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29-2008 **Physician** Month Ellin Hughes 04 -1:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury late 200. Hospice the Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X 217-16-9780 85 Director 12/9/1922 Maryland Usual Residence of Decedent 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Directo Maryland Wicomico 1 XYes 2 □ No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 W. College Ave. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo þ Specify white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Alfred Sullivan Lillian Nibblett ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 W. College Ave., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Donna H. Booth/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place WICOMICO MEMORIAL 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5/2/08 Salisbury, MD 4 Donation 5 Dother (Specify) Park Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Tarre Dompson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DBMRNTIA BND disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760. as 1 IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) as been signed by the 2 should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes → No page 1 Yes 2 Mo the Hospital or Attending Physician; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Ño Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation (Month, Day Year) To the nospose within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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Registrar

DHMH 17 Rev 1/2001

CHUMMY WARY MAY 0 1 2008 31. Date filed (Month,

COASTAZ gistrar's Signature

30. Name and a riess of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

29c. License number

DOOCS 410

29d. Date signed (Month, Day, Year)

? Box 1733 SAUSBRY US. 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Holloway 2:55 AM Physician Ronald Calvin Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur Wicomico indestal. Hospice at the Lake If Under 1 Year | If Under 24 His. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Date of Birth **Funeral** Days Month Day Year) 12/3/1934 1**⊠** M 2□ F 217-30-7778 Maryland 73 Director Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Wicomico Delmar Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a or 21875 USA 8460 Teal Circle Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Ves 2 No 1 □Never Married 2 □ Married If Yes, Give Marine 1 ☐ Yes 2 No Specify: Specify: by white 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) automotive parts owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be Pauline Ida Ruark Edward Calvin Holloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8460 Teal Circle, Delmar, MD 21875 19a. Informant's Name/Relationship (Type. Print) Ronald C. Holloway Jr/son Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 5/2/08 Salisbury, MD 4 Donation 5 Other (Specify) of Funeral Service Lensee ²²Name and Address of Facility
HOILOWAY Funeral Home Professional Association any 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part . Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ROSTATE DWA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician Physician/Medical the for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No certificate has autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ño 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Division or Vital Records, ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th within 2

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Sonold

Registrar

29b. Signature and title of certifier

Hurs

WARY 31. Date filed (Month, Day, Year) MAY 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

00058410

29d. Date signed (Month, Day, Year)

P.01300 173) SAUSBULY US 21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 19 2008 ear 5:50a M **Physician** Hernandez Victoria /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House 8. Date of Birth (Month, Day, Year) 8/26/1926 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. El Salvador 1 □ M 2 13(F 81 215-49-6237 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "inatural", or Items 23a or 28a-f show any injury or other traumatic event, the Medic of Examiner must be notified at any injury or other traumatic event, the Medic of Examiner must be notified at MD Montgomery 1 ☐ Yes 2 No Germantown Director 10g. Citizen of What Country? 10f. Zip Code 20876 10e Street and Number Theseus Terrace 20932 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married No Specify: El Salvadoren 3altimore, Maryland 21215-0036 1⊠ Yes 2□ No White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker i 2 should be filed w h and Mental Hygier 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florentia Hernandez Gregorio Mejia ည 19a. Informant's Name/Relationship (Type. Print)
Lucia Ventura/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20932 Theseus Terrace Germantown, Md 20876 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State Silver Spring, Md. 4/22/2008 d 4 Donation 5 ☐ Other (Specify) Funeral Service Dice PHIME INPAdress RINALDI FUNERAL SERVICE, P.A. 21. Signature of 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the Wease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of Gallbladder Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-trar Due to (or as a consequence of) physician a P.O. Box 68760, Physiclan/Medical use as ed by the attending a detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 XNo 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown advanced dementia Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1∐ Yes 2X No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be ospital or Atten.
24 hours after death.
---ral Director: After this ce Hospital: Other: $_{4\square \, \text{Nursing Home}}$ 5 $\square \, \text{Residence}$ 6 $\square \, \text{Other} \, (\textit{Specify}) \, \, hospice$ 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examprer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To th within 2 o the Fr and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064615 April 19,2008 400 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Dr. Rockville, Md 20850 Wroblewski MD Genevieve

State Registrar 31. Date filed (Month, Day, Year)
APR 3 0 200



ORIGINAL

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2008 Physician April 29, William Franklin Hughes 6:00 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14564 Kelmscot Drive Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year) Months 1 ☐KM 2 ☐ F Days Hours 577-16-4704 87 March 9, Director 1921 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Modical Experience must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14564 Kelmscot Drive 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Yes Give Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 ☐No Specify ≥ If Yes, Give Year or Dates: WWII era Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) C&P Telephone Supervisor permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Rogers Hughes Cornelia Follin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Hughes/Wife 14564 Kelmscot Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 29 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 5 acres 500 University Blvd. W. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or horit failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (rdisease or condition resulting in death) nmediate Cause (Final **Physician** Prostate Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) ed by the detached f 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
Yes 245xNo certificate 1 □Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 【3 Residence 6 ☐ Other (Specify) Certification: To 1∐ Yes 34 No 1 Inpatient this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 🗆 No after death filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signa ture and certifier 29c. License number 29d. Date signed (Month, Day, Year) D35635 April 29, 2008 1041 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, MD 20832 Joseph Kaplan, MD 31. Date filed (Month Da. Dea) 32. Registrar's Signature State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 28, Walter Maxwell April 2008 4:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🙀 M 2 🗆 F Days Hours 90 057-03-5122 Director 11, 1917 New York Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f shevent, the Medical Examiner must be notified Director 1 ∐Yes 2 Lawe Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 15027 Eardley Court death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examinany once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 Nidowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Musical Strings Company Vice President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadye Baum <u>Chester Herman</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Teague Road, Myrtle Beach, SC 29577 Chester Herman/Son 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 🖾 Removal from State Floral Park Cemetery May 1, 4 Donation 5 Dother (Specify) Monmouth Junction, NJ 21. Signature of Funeral Service Licensee 22 Name and Address of Each time Funeral Home Inc. eur 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause o , ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 1 □Yes 2 Division of Vital 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 n who completed cause of death (Item 23a) (Type, Print) Philip Drive, Olney, H MOANDY (8101 State 0 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12 10 A M Johnson 27 2008 ames /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury
Under 1 Year If Und
onths Days Hours Hearn Dicomico -ane Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 (7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 □ F Months 8 Maryland 218-14-1928 Director Usual Residence of Decedent la or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director icomico 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21801 "natural", or items 23a Funeral other traumatic event, the Medical Examiner must ane Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 21215-0036 Specify. ģ Black 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bude permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien important: If item 27 is marked other the any Injury or other traumatic event, the once. Brick Maker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ohnson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisburg James Johnson Son 509 Hearn Lane MD. 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐ Removal from State Maryland VAC 5-2-08 4 □ Donation 5 □ Other (Specify) emeters 21 Signature of Funeral Service 22. Name and Address of Facility 917 W. Isabella Bennie Smith F. H. Salisbury, Mary or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Ent diseas shock, or heart failur Immediate Cause (Fina disease or condition resulting in death) **Physician** UNG CARCINDALA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signaled to page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an was autopsy performed? certificate has 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Matural Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-29-08 2005 2410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUNOX 1737 SACIS BURY UP 21802 CHUAM WARY COASTAL HOSPICA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Division of vital hecolus, r.O. Don 00/00,		Daithinge, Mai yiatid 21
Hospital or Attending Physician: The law requires that the death certificate be executed to the safet death	Phy /M Exa	permit. Pages 1 and 2 should be filed wi
Funeral Director: After this certificate has been signed by the attending physician and	rsid led am	Important; If Item 27 Is marked other th
ely filled in by the funeral director, page 2 should be detached for use as the burial-transit	transit ini	any injury or other traumatic event, the

		For State Registrar AMEND#5perFH				artment of rtificate of				giene Reg. No.	2001	8 15832
Physici		1. Decedent's Name (First, Middle, L Roger Kinder	ast)						2. Date of De- Month April	Day		3. Time of Death 5:59P M
/Medic		4a. Facility Name (If not institution, gi	ve street and nui	mber)		4b. City, Town,	or Location	of Death	Whiti		County of Dea	
LAGIIII		14160 Montice	llo Drive				Cooks	ville			Howa	rd
Funeral		5. Social Security Number 228-68-4473	Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea Months Days		r 24 Hrs. Min.	8. Date of Birl (Month, Da	h v. Year)	9. Bi	rthplace (State or Foreign ountry)
Director		-228-68-1473	1⊠M 2□F	59	Yrs.	Months Buy	710013		July 30			est Virginia
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
//aryla	ō				,,		<i>a</i> 1					1 □Yes 2 ☑ No
the N 28a-	Director	Maryland Ho 10e. Street and Number	ward			10f. Zip Code		sville		10a. Citiz	zen of What C	ountry?
3a or	Ö	14160 Montice	lo Drive				2172	73				5.A.
ms 2	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13. \	Vas Decedent of f Yes, specify Cu			ecify Yes or No	_ 1	14. Race - Am	erican Indian,
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ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		TETTES ZEING	3 Specify				Specify:	White
"natu	ete	15. Decedent's E (Specify only highest g	ducation rade completed)		(Give	lent's Usual Occi kind of work done	e durina mo	st of worki	ng	16b. Kir	nd of Business	s/Industry
withir ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ille. L	DO NOT use retir Mai	ler				Private	Industry
filed Hygi other ent, ti		17. Father's Name (First, Middle, Las	it)		1		1	er's Name	(First, Middle,			21144502)
lld be lental ked (To Be	Everett Clar	ence Kind	er		18. Mother's Name (First, Middle, Maiden Surname) Virginia Mae Sigmon						
shou and N s mai	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Stree	et and Numb					Zip Code)	
and 2 saith a 27 is er tra		Lynda Jo Kinder	- Spouse		14160) Monticel	lo Driv	ze, Co	oksville,	Mary	land 21	723
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Pomoval from	1 0	Place of Dispo cemetery, crer	sition (Name of natory or other pl	ace)		Date	20c. Lo	cation - City o	r Town, State
Pag ment ant: I		4 □ Donation 5 □ Other (Spec			rt Linco	1n Cemete	ry	04/28	/2008	Bre	ntwood,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee		H:	.Name and Add Ines-Rinal 1800 New H	di Fune	eral H	ome, Inc.	er Sp	oring, Ma	aryland 20904
YES		23a. Part1. Enter the dis-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have a few first only one cause on each line.										Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest										Onset and Death
/Medical Examiner		resulting in death)		(or as a consequ								
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ntifica ng ph as th	Med	IF FEMALE:								-		
death certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?		tcome pf pregna pirth 2 ☐ Feta		Ectopic pregnan	cy			2	23d. Date of de	
at the dea by the ar tached fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of d own	eath 5	Other (specify)					Month	Day Year
that the ed by detac		Part II. Other significant conditions	contributing to d	eath but not resi	ulting in the ur	nderlying cause o	iven in Part	I.	23e. Did to	obacco u	se contribute	to the cause of death?
uires that n signed t ld be det	d by	Hypertension	J		J	, , , , , , , ,						Probably 4 □Unknown
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Completed	Diabetes Mellitus			-				24a. Was	an	24b. Were a	autopsy findings available
The lav	E O		h Ci						autor perfo	osy rmed?	prior to death?	completion of cause of
slcian: Th certificate rector, pag	a l	Spondylosis of Lum 25. Was case referred to medical	Dar Sprine				26. Plac	e of Death	1 Yes 1 (Check only o		1 □ Ye	s 2□No
Physical this ce al direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 DOA O	ther:		me 5₺Resid		6 □Other (Sp.	ecify)
dlng Pt n. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Inj			28d. Describe I			
tendl eath. for: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not	20			M 1[☐Yes 2☐]No				
ospital or Attending Physician: hours after death. uneral Director: After this certific. ly filled in by the funeral director, I	Certification:	4 Homicide determined	20e. Place	of injury - At ho ing, etc. (Specif		eet, factory, office	Э		28f. Location (3 City or Tox	Street and vn, State)	d Number or F)	Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) 1 ☑ Certifying F 2 ☐ Medical Example 1	aminer: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date a	and place, eath occuri	and due to the red at the time,	cause(s) date and	and manner a I place, and du	as stated. ue to the cause(s)
To the To the Comp	Me	29b. Signature and title of certifier	ىد. 1	0.			ise number			29d. Date	e signed (Mor	nth, Day, Year)
15		► abch3a	beth.	BICL		DO	052	3+	5	41	25 13	2008
1		30. Name and address of person who Elizabeth Biru, M	·		, , , , ,	,	Hills.	, Mary	land 2074	·8		
Sta		31. Date filed (Month, Day, Year) APR 3 0	32. F	strar's Signa	ture				_			
Registi	rar	MENOU	2000	Robert .	St Pa	03462)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** June Livingston 26 2008 /Medical tori 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 220-28-2024 1 ☐ M 2 🗙 F 75 Director 6/11/1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Funeral Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4417 Nutters Cross Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No by Specify white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cafeteria manager Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Quillen Howard S. Pruitt ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Livingston/son 29046 Tanger Way, Eden, MD 21822 alfimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 4 Donation 5 Dother (Specify) 5/1/08 Salisbury, MD Park 21. Signature of Funeral Service Lixin Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bac **Physician** teria weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? almonday Desedse 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ ij 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

5 MT

220-38-3024

Registrar
DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

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04-26-08

SALISBURY, MD. 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Walter Ludke 17:25 P.M. \$ 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F Days Hours Min 80 579-30-5962 8/19/1927 Washington, DC Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No Director Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26783 Quantico Creek Road 21830 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) minister religion 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Anna Rupert August Albert Ludke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26783 Quantico Creek Rd., Hebron, MD 21830 Barbara Ludke/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 4/30/08 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service L 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYSTEM OREM FAMILE a MULTIPLE disease or condition resulting in death) 2 DAYS Due to (or as a consequence of) b. force and more VALVE 2 MARILY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 → No 3 □ Probably 4 □ Unknown Completed 24b Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

/Medical Examiner The law requires that the death certificate be executed burial-tran and P.O. Box 68760, the signed by the a Records, page 2 s certificate has or Vital director.

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

er than "natura", the Medical E

es 1 and 2 should be file of Health and Mental Hitem 27 Is marked other other traumatic even

permit. Page Department of Important: If any Injury or once.

Physician

Pages 1 ₽ 9

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Physician:

Hospital or Attending Division after death. 24 hours a

completely within 2

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Medical

Todd 1 2008

6 ☐ Could not be

determine

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

(Check only

29b. Signature and title of q

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) D53551

adical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E Carrollst. Salesbury MD. 21801 PRMC Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death April 27, 2008 Rosemary Patricia Leary 11:35 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4808 Creek Shore Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea June 26, 6 Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Months Days Year) Hours Country) \ Illinois 1 □ M 2 1 F 356-10-3012 Yrs June 1921 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4808 Creek Shore Drive 20852 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐XNo 1 ☐Yes 2 No White Specify: 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph McNamara Bernice Roberts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Patricia Arkin/Daughter 17204 MacDuff Avenue, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 1, Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2008 | Silver Spring, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiorespiratory Arrest 3d. Date of delivery Month Year e contribute to the cause of death? 3 Probabły 4 Trunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No ☐ Other (Specify)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hury or other traumatic event, the Modifical Exercite traumate be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

2

Completed

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physician a the burial-1 the certificate has breacter, page 2 s s after dea... rai Director: Aft filled 24 hours

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Alzheimer's Disease Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of):	
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Ye a
Completed by P	Part II. Other significant conditions of Status Post Pace	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat 1
Be (25. Was case referred to medical examiner?	26. Place of Death	
	1 Yes 2 XX No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Other: 4 Nursing Hor	me 5 🔀 Residence 6 🗌 Other (Specify)
Medical Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	nysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
ž	29b. Signature and title of certifier	29c. License number	29d Date signed (Month Day Year)

20

To the I within 2

completely

State Registrar

31. Date filed (Month, Day 2008

29b. Signature and the of certifier





D45296

29d. Date signed (Month, Day, Year)

April 30, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

			1 - State Registrar	_	Cei	tificate of l	Death		Reg. I	No. 2008	15836	
п	Physici	an	1. Decedent's Name (First, Middle, Last)	T					te of Death onth			
- 10	/Medi			Littleton					il 27,	2008	2:30 p ^M	
	Examir	ner	4a. Facility Name (If not institution, give street an	,	4b. City, Town, or Location of Death			eath		4c. County of Deal	h	
- S	Formul		Brighton Gardens, Boundary Science Brighton Gardens, Boundary Science Brighton Gardens, Boundary Brighton Brighton Gardens, Boundary Brighton Gardens, Brigh	ethesda 7. Age (In yrs. lasi	hirthday)	Rockvil If Under 1 Year		Hrs. 8 Da	te of Birth		gomery hplace (State or Foreign	
	Funeral Director		578-09-3157 1□M 2½		Yrs.	Months Days		vin. (M	onth, Day, Yea	ar) Co	nuntry)	
			Usual Residence of Decedent	196				Ju	ne 23,	1911 P	ennsylvania	
	rylan ihow	_	10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits	
	e Ma	9	Maryland Montgomery	N	orth	Bethesda					1 □Yes 2 🙀 No	
	ith th	Director	10e. Street and Number			10f. Zip Code		-	10g.	Citizen of What Co	untry?	
	ath w	ral	5550 Tuckerman Lan				852			USA		
	ltem.	Funeral	Arme	Decedent Ever in U.S. of Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	? (Specify Ye uerto Rican,	s or No- etc.)	14. Race - Ame Black, White		
36	filed within 72 hours after death with the Maryland Hygiene, wher than "natural", or items 23a or 28a-f show ont, the Modical Exerciting roust be notified at		If Yes	′es 2. ZANo s, Give orDates:	1	□Yes 2 🛣 No	Specify:			Specify: W	hite	
ŏ	2 hou	Completed by	15. Decedent's Education	T 1	6a. Deced	ent's Usual Occupa	ation		16b.	Kind of Business/	Industry	
21215-0036	thin 7 e, an "n	agr.	(Specify only highest grade completed and Secondary (0-12) Elementary/Secondary (0-12) Collete	ted) ge (1-4or 5+)	(Give l life. L	kind of work done o OO NOT use retired	luring most of ()	working				
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nd	be file	B	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First,	Middle, Maid	en Surname)		
<u>\</u>	should band Ment s marked umatic e	은	Joseph Gursky				lizabet					
Maryland	h and h snd risma rraum		19a. Informant's Name/Relationship (Type. Print)	. 1		g Address (Street a						
	1 and Health em 27 Ather to		Preston A. Littleton, 20a. Method of Disposition			1907 Whi	stler (Date				
altimore,	S of H		1 Burial 2 ☐ Cremation 3 ☐ Removal f	rom State ceme	etery, crem	atory or other place	1.10	ay 2,	200.	Location - City or	rown, State	
≣	permit. Page Department Important; If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Gate		leaven Cer		2008	Si	lver Spr	ing,_Maryland	
Ba	permit Depar Impor any in once.		21. Signature of 1 different Service Electrises			Name and Addres						
			23a. Part 1. Enter the disease, or complications to	nat caused the death. I	Do not ente	or the mode of dying	sity R] g, such as card	Lvd., diac or respi	W. Sil: ratory arrest,	ver Spri	Approximate Interval Between	
	Physician		shock, or heart failure. List only one cause Immediate Cause (Final	on each line.							Interval Between Onset and Death	
	/Medical			gastive He e to (or as a consequen		ailure						
	Examiner	Sequentially list conditions. b. Atherosclerotic Heart Disease										
	₽ #	ner	Sequentially list conditions, it also have been been been been been been been be	e to (or se a consequent	oe of j:	OL ULBU						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events c.	op Venous T		osis						
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×	certifi Iding Se as		IF FEMALE: 23c If yes	, outcome of pregnancy		-1		30				
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oj.	w requires that the de been signed by the should be detached	Physi		Jnknown		Ottler (specify)						
~. J.	The law requires that ate has been signed b page 2 should be deta	by P	Part II. Other significant conditions contributing	to death but not resulting	g in the un	derlying cause give	n in Part I.	23	e. Did tobacc	o use contribute to	the cause of death?	
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ပ္တ	E S C	Completed						24	a. Was an	24b. Were au	topsy findings available	
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		0	25. Was case referred to medical				26. Place of D]Yes 2 ⊊₄ 1 k <i>only one</i>)	vo I ∐ Yes	2 □No	
-	Si di	To B	examiner? 1 ☐ Yes 2 🖾 No Hospital:	I ☐ Inpatient 2 ☐ ER/	Outpatient	3 □ DOA Othe				6 ☐ Other (Spec	cify)	
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<u> </u>	tendi eath. for: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □ Y	′es 2□No					
DIVISION	or At ifter d Direct in by	ertification:	determined 200. P	lace of Injury - At home, uilding, etc. <i>(Sp</i> ec <i>ify)</i>	farm, stre	et, factory, office		28f. Loc City	ation (Street of or Town, Sta	and Number or Ru ate)	ral Route Number,	
_	pital ours a eral i filled	O	29a. Certifier 1 Certifying Physician: To	the heet of muslimous	day desti-	nonurrad at the co	no deta an i i	lene == : :	A	(=) === :)	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only \ 2 \square Medical Examiner: On t	o the best of my knowled he basis of examination manner stated.	and/or inv	estigation, in my op	ie, date and pl pinion, death o	ace, and due occurred at th	e to tne cause e time, date a	(s) and manner as and place, and due	to the cause(s)	
	Nithin To the	Me	29b. Signature and the of certifier		7	29c. License	number		29d. [Date signed (Month	ı, Day, Year)	
N	10		1 Try redd		Mo	D5369	91			April 28,		
	, ,		30. Name and address of person who completed	cause of death (Item 23)	a) (Type, P	rint)						
			Ajay Reddy, MD 6320	Democracy			sda, MD	2081	7			
	Sta	te	31. Date filed (Month Day Year) 0 2008	2. Registrar's Signature	e A	2000 1						
	Registra	ar		Partition for	Ser Service	San San San San San San San San San San						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year 2:15 p.^M CLAYTON PAYNE LIBEAU MAY 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 8751 Pete Wiles Road Middletown Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 89 217-14-7395 Oct. 23, 1918 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√ No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8751 Pete Wiles Road 21769 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 42-46 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21√2 No Specify. Specify: 3 Nidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Economist S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donation Libeau Fannie Byrd Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Libeau/son 8751 Pete Wiles Road, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory May 12, 2008 Smithsburg, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature Funera 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Enter the dise shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a considence of) Coronavu Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

ed by the a detached f

this funeral

within 24 hours after death

To the Funeral Director: completely filled in by the f

0

certificate be executed

P.O. Box 68760,

Division or Vital Records,

Physician

/Medical

Examiner

Director

Funeral

3

Completed

Be

Funeral

Director

show

d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medic Ex. miner must be notified at

Pages 1 and 2 ment of Health a lant: If Item 27 is lury or other tra

Injury or Department of Important: If any Injury or once.

Saltimore, Maryland 21215-0036

Sequentially list conditions Examiner transplacement and the state of attending physician and for use as the burial-trans

Physician/Medical

9

Completed

Be

Certification:

Medical

0

State Registrar

autopsy performed? Yes 2. No 1∏ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

and manner stated

MD

MO

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 Natural

3 ☐ Suicide

2 ☐ Accident

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Myersville MD

26. Place of Death (Check only one)

29b. Signature and title of certifie Wa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

D0058726

Ct

May 9,2008

Vette Warren 31. Date filed (Month, Day, Year)

3000 - D

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Ventrie

State of Maryland / Department of Health and Mental Hygiene 1- State Amended items 16a&b, 5/5/08, WCHD STITICATE of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day
April 29, 2008 Physician Miles Albert. 10:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomico 908 Outten Road Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1**X** M 2□ F 69 Director 230-56-8102 4/4/1939 Virginia Usual Residence of Decedent s and 2 should be filed within 72 hours after death with the Maryland Health and Merital Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 TXYes 2 □ No Funeral Director Wicomico Salisbury Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or ms 23a 21804 USA 908 Outten Road 14 Bace - American Indian r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Rubberset/Sherwin Give kind of work done during most of working life. DO NOT use retire **Factory Worker** Elementary/Secondary (0-12) College (1-4or 5+) Wildrigs Fa Chocolate Co paint shop worker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked traumatic ev Albert Miles Minnie Pruitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 908 Outten Rd., Salisbury, MD 21804 Rose Preston/friend item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: if it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/2/08 Pocomoke City, MD 1st Baptist Cemetery 21. Signature of Funeral Service License 22.Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Peritoneal Mesothelioma 1 4 COZ Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Small bowd do streetin Examiner Intermittent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant atten for u 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Year 4□Pregnant at time of death 9□Unknown in the past 12 months? Month 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? yperten 870h Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed COLONON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? res 221 No certificate 1□ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 ō After thi funeral of 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide b To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) may 1, 2008 D0014314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E Canell Stu7, Solisbury, MD. 21801 PANPIT P. KLUG 3 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 1 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Rodney Paul Mitchell, Jr. 11:40 A M 2008 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 323 Martins Cove Road Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 🛛 M 2 🗆 F 214-48-1237 60 Director Dec. 19, 1947 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show Anne Arundel Annapolis Maryland 1 ☐Yes 2XNo Directo 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be an once. 21409 U.S.A. 323 Martins Cove Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Yes. Give Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) County Schools Network Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rodney Paul Mitchell, Sr. Doris Naomi Whittington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 323 Martins Cove Road Annapolis, Maryland Alicia Hardisky Mitchell/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/29/2008 Ft. Lincoln Crematory Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancreance one year **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if only leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year i signed by the a d be detached for 5 Other (specify) Ö ☐Yes 2☐No 9 ☐ Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2: autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ours after death.

neral Director: After this
filled in by the funeral di Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Note of Print P. CELONICH, W. 900 Bestgate Rd. Annapolis, Md. 21401 APR 2 9 2008 32. Redistrar's Signature 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 07:05AM 75 2008 ITCHELL APRIL DORIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Dave Hours Min. 8. Date of Birth (Month, Day, Year) July 25, 1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2XX 79 Maryland 219-20-2056 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Chevy Chase MD 1 □ Yes 2 No Montgomery Director 10f. Zip-Code 20815 10g. Citizen of What Country? 10e. Street and Number apt.520 North Park Avenue 4601 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 11. Marital Status 1 ☐ Yes If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3x Widowed 4 □ Divorced A merican Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bowie Mamie Edm ond Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen E. Mitchell Starika (daughter) 1817 Parkside Drive, NW, Washington DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/2/2008 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses Indro Tho 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Gastrointestina /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Tectopic pregnancy in the past 12 months?

1
Yes 2 No Month Dav 5 Other (specify) n signed by the att 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has The 2 🗆 No 1 Ves 2 XNo 1 Yes I or Attending Physician: The after death.

Director: After this certificate ! 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident by the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Cify or Town, State) filled in To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10

State Registrar PEMMARAJU 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

600 North Wolfe St, Baltimore, MD, 21287

29c. License number RES-000 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

other

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and the attending physician the nse for this After t Hospital or Attending within 24 hours after death To the Funeral Director; filled in by the

5 ☐ Pending investigation 1 ☐ Yes 2 Accident 2 ∏No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Year) 31. Date filed (Month, 2008 0

ATHLEEN

Registrar

		1 - For State Registrar	ate of Maryland / D	Department of H Certificate of I			2008	15842
Physic /Med		Decedent's Name (First, Middle, Last)	eon McKane	e		ate of Death Jonth 10,	2008 ^{ear}	3. Time of Death 6:35 p M
Exami Funeral Director	ner	4a. Facility Name (If not institution, give street 208 Baughman's Lane 5. Social Security Number 218-24-8973	7. Age (In yrs. last birt	Frede	If Under 24 Hrs. 8 D	ate of Birth donth, Day, Year	Frederic 9. Birthr Court Mary	k blace (State or Foreign http:) y land
70		Usual Residence of Decedent 10a. State 10b. County Maryland Frederick	10c. City, Town	or Location ederick		, 133 		10d. Inside City Limits 1 XYes 2 No
h with the	Funeral Director	10e. Street and Number 208 Baughman's Lane	•	10f. Zip Code 217	702	10g. Ci	tizen of What Coul	ntry?
peritinities in the state of the state of the state of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at any injury or other traumatic event; the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Mayes 2 □ No 1951 - Yes, Give ear or Dates: 1954	1 ☐ Yes 2 1 No	lispanic Origin? (Specify \angle Specify \angle Specify:		14. Race - Americ Black, White, Specify: Whi	etc. ite
within 72 h ene. than "natu he Medica	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) 5 + Jt	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired uvenile Just	during most of working di) ice System		Kind of Business/In	
ild be filed lental Hygi ked other ic event, t	To Be Co	17. Father's Name (First, Middle, Last) Scott Raymond	McKane		18. Mother's Name (First Margaret	Reat	^{n Surname)} Basore	2
nd 2 shou alth and M 27 is mat r traumati	-	19a. Informant's Name/Relationship (Type. Pr Joyce McKane, Wife	int) 19b.	. Mailing Address <i>(Street</i> 08 Baughman	and Number or Rural Roll s Lane, Fre	_{ute Number, City} derick,	or Town, State, Zip Maryland	20de) 21702
Pages 1 a		20a. Method of Disposition 1 1 Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)		Disposition (Name of ry, crematory or other place Hill Cemeter			ocation - City or Togerstown,	own, State Maryland
permit. Departr Imports any Inji		21. Signature of Funeral Service License	M00706	Keeney &	Basford P.A hurch St, Fi	A. Funer rederick	al Home , Marylan	nd 21701
Physician /Medical Examiner		23a. Part1. Enter the Jisease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	^	nonia	ng, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of					
the death certific the attending properties	Physician/Me	in the past 12 months?	yes, outcome pf pregnancy □Live birth 2 □ Fetal death □Pregnant at time of death □Unknown	a 3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deliv Month	very Day Year
w requires that the been signed by should be deta	b	Part II. Other significant conditions contribut		, ,			use contribute to	the cause of death?
The law rate has be page 2 sho	Completed	Cerebro	ion Vasculor	Stroke		24a. Was an autopsy performed? 1∐ Yes 2XN	prior to co	opsy findings available ompletion of cause of 2017 No
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as I	Certification: To Be	1 Natural 5 Pending investigation	a. Date of Injury 28b.	Time of 28c. Inju Wo 1	ry at rk? Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Residence Describe how inj	ury occurred	
Hospital of the hours at Funeral D tely filled i	edical Ce	(Check Ny 2 Medical Examiner: (To the best of my knowledge on the basis of examination ar					
To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens			Pate signed (Month	
\'.	7	30. Name and address of person who comple	-17	(Type, Print)	D 5/643	5	212	.v2
S Regis	tate trar	31. Date filed (Month, Day, Year) MAY 1 4 2008	32 legistrar's Signature	Specie	- CVIII		,,/	

Physician Division of Vital Records, P.O. Box 68760,

/Medical Examiner burial-transit use as the be detached for Hospitel or Attending after death. within 24 hours after To the Funeral Direct completely

Physician

Examiner

Funeral

Director

or 28a-f show

naturel', or Items 23a

permit. Pagas 1 and 2 should be filad within 72 hours after of Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item any injury or other traumatic event, the Medical Examinat once.

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

2

Physician/Medical

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Completed

Certification:

Medical

other traumatic event, the Medical Examiner must be notified at

/Medical

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKRAMADIT 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

DONAL M.D. 32 Registrar's Signature

924 SETON DR. CUMBERLAND, MD ZISCA

29c. License number

D36766

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2008 Mpri Sarah Catherine Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 21 F March 6, 1928 Director 218-20-7749 80 MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 NX Director Wicomico MD Quantico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21856 23762 Head-of-Creek Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Laborer 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Alberta Evans Robert Douglas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23762 Head-of-Creek Road - Quantico, MD 21856 Elsie Robinson Wallace/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State St. James Free Meth. Ch 5/4/2008 Quantico, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign store of Funeral Service License 22. Name and Address of Facility Salisbury, Maryland 21801 Jolley Memorial Chapel, P.A. - 1213 Jersey Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform<u>ed</u> 1 Yes 2 No 25. Was case referre to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manne of Death 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 127/08

State Registrar Christian Hudd 31. Date filed (Month, Day, Year)

MAY 0 1

Huddleston

2008

P477-06-

ess of person who completed cause of death (Item 23a) (Type, Print)

100E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 0.000

			1 - For State Registrer	State of Ma	aryland /			nt of H		ivie		g. No.	008	15645	
			Decedent's Name (First, Middle, La	ist)						2	Date of Deat Month		Year	3. Time of Death	
	Physici /Medio		Suzanne Kreine:	r Redmond								28, 2		1:35 p M	
	Examir		4a. Fecility Name (If not institution, gir						Location of De			4c. Co	ounty of Death		
			10704 Bucknell						Sprin	-				gomery	
	Funeral Director		450-80-0640	Sex 7. Ag 1 ☐ M 2 🗗 F	e (In yrs. last 61	birthday) Yrs.	Months	er 1 Year Days	If Under 24 H Hours M	in.	Date of Birth (Month, Day, Aug • 5,	^{Year)} 194	9. Birthp Cour 6 Cal	place (State or Foreign ntry) Lifornia	
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						1	10d. Inside City Limits	
	e Ma	cto	Maryland Mon	ntgomery	:	Silve	r Sp	ring						1 Yes 2 No	
	h with th	al Dire	10e. Street and Number 10704 Bucknel:	l Drive			10f. Z	ip Code	20902		1	0g. Citizei US	n of What Coul A	ntry?	
980	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show ha Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Narried 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:				edent of Hi ecify Cubai 2XXIo	spanic Origin? n, Mexican, Pu Specify:	(Specification (Speci	y Yes or No- an, etc.)		. Race - Americ Black, White, pecify: Whit	etc.	
2-0	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation ade completed)	1	6a. Deced	dent's Us	ual Occupa	tion	workina		16b. Kind	6b. Kind of Business/Industry		
21215-0036	within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Nur		use retired,	uring most of			Hospital			
Þ	Pages 1 en tment of Hee tant: if item jury or other	Be C	17. Father's Name (First, Middle, Las	")					18. Mother's I	Vame (A	irst, Middle, M	Maiden Surname)			
/lar		ToB	Thomas Joseph B	reiner					Ber	nice	e Colet	ta G	a Gulan		
Maryland			19a. Informant's Name/Relationship (Type, Print) Daniel P. Redmond/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 10704 Bucknell Drive, Silver Spring, II 20a. Mathod of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State, 10704 Bucknell Drive, Silver Spring, II 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State, 10704 Bucknell Drive, Silver Spring, II												
Baltimore,			20a. Method of Disposition 1/CXBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ceme	etery, cren	natory or	other place	I VI		Date 20c. Location - City or Town, State 30 Arlington, Virginia				
Ħ			21. Signature of Funeral Service Lice	**	Ceme	tery	. Name	tiona						VIIginia	
B	Departimon important in portant i		500 University Blyd. W., Silver Spring, MD												
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									Approximate Interval Between Onset and Death				
resulting in death)														21 Weeks	
68760,	requires that the death certificate be executed XX een signed by the attending physician and XX nould be detached for use as the burial-transit	Due to (or as a consequence of):													
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel de	ath 3	Ectopic Other (s	pregnancy specify)				230	d. Date of delive Month	ery Day Year	
	ires that signed b d be deta		Part II. Other significant conditions	contributing to death b	ut not resultin	ng in the ur	nderlying	cause give	n in Part I.			accouse		he cause of death?	
Ö	w requir been si should I	etec								-					
Division of Vital Records,	a SO	Completed by								-	24a. Was a autops perforr 1 ☐ Yes 2	n y ned?	prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of	
/ita	clan: ertific ictor,	Be (25. Was case referred to medical examiner?							Death (Check only on	е)			
7	Physician: this certific ral director,	ည	1 ☐ Yes 2 ☐XNo		ent 2 ER				7				Other (Specif	(y)	
ion	ter Ter	atlon:	27. Manner of Death 1Ă☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry y Year) 28	b. Time of Injury	м	28c. Injury Work 1 🗆 Y	at ? ∕es 2 □ No	286	d. Describe ho	ow injury o	occurred		
Divis	al or Atte s after de si Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ury - At home c. (Specify)	, farm, str	eet, facto	ory, office		28	. Location (St City or Town	reet and f n, State)	Vumber or Rura	al Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying P (Check only 2 Medical Exe	hysicien: To the best miner: On the basis o and manner st	l examination	dge, death and/or inv	occurre vestigation	d at the tim on, in my op	e, date and pl	ace, and	due to the ca at the time, d	ause(s) ar ate and pl	nd manner as s lace, and due t	stated. o the cause(s)	
	withir To th	Me	29b. Signature and title of certifier	1			2	9c. License	number		2	9d. Date s	signed (Month,	Day, Year)	
	20		-	h					VA010					29, 2008	
	00		30. Name and address of person who Gaylord Scott Ro						eorgia ical C		e., NW,	Was	hingtor	n, DC 20307	
	Sta		31. Date filed (Month Par Year)	2008 32. Registr	ar's Signature	4	Par A	6 a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Day **Physician** 300 Patricia Ann Stamper APRIL 29,2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE LEVINDALE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 XF 69 Director 405-54-4353 Aug. 22,1938 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes X☐No Director Indian Head Maryland Charles 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 5110 Mason Springs Road 20640 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Mathematician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H ttem 27 is marked oth Be Virgin Anna Joseph Carter Cain, II ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5110 Mason Springs Rd., Indian Head, Md. 20640 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other troones. John A. Stamper Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) May 6, 2008 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Georgetown, Kentucky Georgetown Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt fails re. List only one cause on each line. Immediate Cause (Final LUNG CARCINOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical as attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 X No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the 27. Manner of Death Certification: After t Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely To the I within 2.

Maryland 21215-0036

Baltimore,

Box 68760,

P.0

Division or Vital Records,

State Registrar 31. Date filed (Month, Day, Year) 2008 MAY 0

Bliron H. WOWETHINOT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

, 2434 IX BELVEDERE AVE, BALTIMURE, MB 21215 GIZAWI WOLDEHIWOT, MD 32. Registrar's Signature

29c. License number

D0063327

29d. Date signed (Month, Day, Year)

04/29/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician May 7, 2008 1:10am Sporkey Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Golden Living Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Days MI 1 □ M 2 🛶 F Jun 19, 1913 Director 220-10-7048 94 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cumberland 1 Yes 2 No MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 1510 Oldtown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married 1 ☐ Yes 2 ☐ **X**o Baltimore, Maryland 21215-0036 Specify: Completed by white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Head of Typing Pool 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta Gilboy Herbert F. Sporkey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) MD 21502 510 Ridgewood Avenue Cumberland friend William Mantheiy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 5/13/2008 MI Escanaba 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 2 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for 1 in the past 12 months? 1☐ Yes 2☐ Mo. Day 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2: perform within 24 hours after death.

To the Funeral Director: After this completely filled in because. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physici : To t e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Nedical Examin : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and anner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 SETON DR. CUMBERLAND, MD OONAI, M.D.

State Registrar 31. Date filed (Month,

Day, Year)

14

2. Registrar's Signature

08-03375 George Sparrow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008 15848

		1- For State Registrar					Certific	ate of	Death				Re	eg. No.	6	UU	0 1004
Physicia		Decedent's Nam	e (First, Midd	le,Last)									Date of Dear	th		7	3. Time of Death
edical Exami		George	W. Spa	rrow	Tr								Month May 3, 20	Day 08	Year		0650 hrs
con.		4a. Facility Name (if not institution	on, give str	eet and nu	ımber)		4	b. City, To	wn, or Lo	ocation of		, -,		ounty of I	Death	
		Peninsula F				·			Salisbury					Wicomico			
Funeral		5. Social Security I	Number	6. Sex		7. Age (In	yrs. last bir	thday)	If Under	1 Year	If Under	24Hrs.	B. Date of Bir	th(MM/DD			place (State or
Director		222-14-	6630	1 X M	2 F		84	Yrs.	Months	Days	Hours	Min.	April 1	7 100		Foreign Cour	ntry) MD
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any		10a. State	10b. County			100	. City, Town	or Location	on							7	10d. Inside City Limits
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Maryland 28a-f show	흕	10e. Street and Nu					DCIII	-	10f. Zip ('ode			[1	0g. Citizer	of What	t Count	n/2
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	Funeral	11. Marital Status			. Was Dec	cedent Eve	r in U.S.				anic Origir Mexican, F		ify Yes or No	- 14	. Race White,		an Indian, Black,
death w or items	5	1 Never Marri	ed 2 X M	arried 1	1 X Yes 2 No ed of Dates: 1943-1946 1 Yes 2 X No												
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ours xam		15. Decedent's E	ducation (Spe	cify only h	fy only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of							d of Busin	ness/in	dustry			
6 72 h ran "n	Completed	Elementary/Sec	ondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)														
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5-0 led w Hygid		17. Father's Name	(First, Middle	, Last)						18	8.Mother's	Name (F	irst, Middle,	Maiden Su	rname)		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be		W. Sparrow, Sr. Lucy Lang														
ould Me	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route									al Route Nur	nber, City	or Town,	, State,	Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiera. Important: If tiem 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner.		Elizabe		rrow	(W	ife)		8577	Delm	ar R	load	De]	lmar,				
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Dep Dem Dem Injury	l ly	O. m.	Show	-	Jew	011.		Sh	ort	Fune	ral H	Iome		1	DT	1.0	010
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/Medical		failure. List or			ine.												Between Onset and Death
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	ē	Sequentially list co if any, leading to in	nmediate		to (or as a	conseque	ence of):										
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ed Isit	Examiner	events resulting in	death) Last	Due	to (or as a	a conseque	ence of):										
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ding Ph.	딭	27. Manner of Dea	th		28a. Date (Mont)	e of Injury h, Day,Year)	28b.	Time of Ir	njury 2	Bc. Injury	at Work?	2	8d. Describe	how injury	occurre	d	
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5 4 E 9		29a. Certifier 1	Certifying P	hysician:	To the be	st of my kn	owledge, de	eath occurr	red at the	ime, dat	e and place						
To the Hos within 24 h To the Fur completely	Medical	one) 2 🗸	Medical Exa	miner:On	the basis	of examina	ation and/or	investigati	on, in my	opinion,	death occ	urred at t	he time, date	and place	, and du	ie to the	cause(s)
₹ ½ ₹ 8	Me	29b. Signature and	title of certific		d manner s	stateu.		· · · · ·	29c.	License	number			29d. Da	ite signe	d (Mon	th, Day, Year)
		Dat			120	00				O.C.N	Л.E.			May 4	4, 2008	3	
		30. Name and add	ress of person	who com	pleted car	Se of rions	h (Item 22c)							1			
		Patricia Arc					lical Exan		111 Pe	nn Str	eet, Bal	timore.	MD 2120)1			
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Regist	rar	31. Date filed (Mod	AY U 9	2008	De	egistrar's S	N.	And									

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Shankle Garry May 12, 2008 8:21 Lee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick 5410 Mountville Road Adamstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 x M 2 □ F 216-48-6751 59 Director 1948 July 31, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exaction or other traumatic event, Ite Medical Exaction or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21710 5410 Mountville Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 1969-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ White Specify: 3 Widowed 4 Divorced 1973 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Frederick County Maintenance Technician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lavier T. Shankle Catherine Virginia Baker ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5410 Mountville Road, Adamstown, Maryland 21710 Dawn Janette Shankle / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Manor Cemetery May 14, 2008 Adamstown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** xtensiuz 2 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate performed? 1 □ Ýes 2 **N**o 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2₽No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral Direct npletely filled in by determined 4 ☐ Homicide 24 hours 29a. Certifier t 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number D146 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a NT 56 515

Registrar

State

31. Date filed (Month L

Year)

Registrar's Signature

			Please T	ype or Print in Black In			15050
		4	For State	State of Maryland / Depa	artment of Health and M <i>rtificate of Death</i>		15850
			Registrar		Tillicate of Death	Reg. No.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last) Jeanne Ngour	- 1 . L .		April 200, 2008 ar	
	/Medic Examin		4a. Facility Name (If not institution, give s Holy Cross Ho		4b. City, Town, or Location of Death Silver Spring		omery
	Funeral Director		5. Social Security Number 579-06-5213 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		rthplace (State or Foreign Country) meroon
	p .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Marylar f show led at	jo	MD 10a. State 10b. County Prince				1 □ Yes 2 No
	with the I 3a or 28a- it be notif	Funeral Director	10e. Street and Number 2314 Banning	Place	10f. Zip Code 20783	10g. Citizen of What C	Country?
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.) 14. Race - An Black, Wh	
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Baltimore, Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last) Jacques Tchou	ante	18. Mother's Nam Moniqu	e (First, Middle, Maiden Surname) e Tchakounte	
Maryl		-	19a. Informant's Name/Relationship (Ty Nathalie Tchoua		ing Address <i>(Street and Nu</i> mber or Ru 4 Banning Place	ral Route Number, Cify or Town, State Hyattsville, M	d. 20783
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Place of Disp cemetery, cro	ematory or other place)	Date 20c. Location - City	
mo	permit. Pages 1 Department of H Important: If ite any injury or ot	Ы	1 Marial 2 □ Cremation 3 Mar 4 □ Donation 5 □ Other (Specify)	Family	Cemetery 5/10	0/2008 Bangangt	
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	9 Q F # 9	_	Milly, DYTHE	lications that caused the death. Do not el	241 <u>Columbia</u> Bl	or respiratory arrest,	Approximate Interval Between
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Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transiti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		B⊟Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of Month	delivery Day Year
ls, P.0	requires that the een signed by the nould be detache	þ		ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribut 1 □ Yes 2⁄€ No 3 □	e to the cause of death? Probably 4 Unknown
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Records,	ding Physician: The law n. After this certificate has b funeral director, page 2 st	Completed				performed? deat	to completion of cause of h? Yes 2 No
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0 0	Ing Pl	i.i	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how injury occurred	
Division or Vital	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
_	Hospital 4 hours: Funeral tely filled		29a. Certifier 1 ☑ CertifyIng Ph (Check only one)	nysiclan: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and placer investigation, in my opinion, death occ	e, and due to the cause(s) and manne curred at the time, date and place, and	er as stated. due to the cause(s)
	To the within 2 Fo the complete	Medical	29b. Signature and title of certifier	and mainer states.	29c. License number	29d. Date signed (A	Month, Day, Year)

State Registrar

31. Date filed (Month, Pay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ram Trehan M.D. 1400 Forest Glen Rd. Silver Spring, Md 20910

3

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. CUUI Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** W. Thompson Charles 7:58A May 2008 6. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cheverly Prince Georges Prince Georges Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 1**3**2 M 2 □ F Months Days Hours Min 57 Yrs. July 13,1950 <u> 251–78–7543</u> SC Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Temple Hills PG Md. 10e. Street and Number 10g. Citizen of What Country? United States 2828 Keating Street 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Engineering 12 Howard Univ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles W. Thompson Sr. Lauree Jeter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2828 Keating Street Patricia A. Perrin/wife Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/12/08 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/12/08 4 ☐ Donation 5 ☐ Other (Specify) Carlisle, SC Luke AME Zion Church Cem. 21. Sign thre of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZEIMERS DEMENTIA Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SÉIZURE DISORDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 | Yes 2 | No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, been signed by the should be detached this certificate has all director, page 2 s

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show mut; If item 27 is marked other than "natural", or items 12a or 28a-f show uny qrother traumatic event, I're Mydical Examiner mast be notified at uny qrother traumatic event, I're Mydical Examiner mast be notified at

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Department of Health as
Important: If item 27 is
any Injury or other trau

Physiclan /Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed funeral director, Be Certification: To To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral After t

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

4 Homicide 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D0058290 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESHKUMBR MUTTATH, 5711 SARVIS AUENUE, RIVERDACE, MD

Mn

State Registrar

Medical

Day, Year) Registrar's Signature MAY 1 4 2008

Provision (Control of Section 1) Description (Contr				For State Registrar	State	of Marylar		artment of H		Mental Hygi	ene g. No. 2 ()	0.8	1585	52	
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State Registrar MAY 1 4 2008 32 degistrar's Signature APPLIANCE 32 degistrar's Signature 21701		6		30. Name and the offers	no completed ca	use of death (Ite	m 23a) (Type,	Print)	110	Ane F	ande.	inch	Mr)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5-9-2008 **Physician** Donald G. Backus, Sr. 2:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1225 Leeds Terrace Arbutus Baltimore 8. Date of Birth
Month Day Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours Min 77 217-26-7787 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-f show 10b Counts 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "inatural", or items 23a or 28a-f show any lajury or other traumatic event, the Medical Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2 No Director Arbutus 10e. Street and Number 1225 Leeds Terrace 10f. Zip Code 10g. Citizen of What Country? 21227 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 № Yes 2 □ No 1949 – If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Cory Backus Gertrude Rose Wolfe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude V. Backus, wife 1225 Leeds Terrace Arbutus, MD. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 ment of F Lorraine Park Cemetery 05-13-08 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. 21. Signature of Funeral Service Licensee Taker Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be execute attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 🔲 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

VXI

DHMH 17 Rev 1/2001

State

29c. License number
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8186 CARX BROWN Rd, MD 21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** May 13 2008 12:45 Marjorie King Bul
4a. Facility Name (If not institution, give street and number) _Bullock /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Keswick Multi Care Center N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 5 1927 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Months Days Hours Yrs. 224-30-5961 80 Pennsylvania **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No N/A Director MD **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 702 Brookwood Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Denoon King ပ Mary Beulah Culpepper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Brookwood Road, Baltimore, MD William C. Bullock - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/14/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nonths **Physician** Or /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and doe detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. <u>\$</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2□ No 1∐ Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ! Charles J. Galto MJ 2120x ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 6701

sistrar's Signature

12

2008

31. Date filed (Month, Day, Year) MAY 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 14, 2008 9:00 A M Kenneth W. Buckley 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Genesis Long Green Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Months Days Hours 1X M 2□ F 220-38-6370 66 1941 July 16, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ¶Yes 2 No Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 3662 Keswick Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) City Of Baltimore Security Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3662 Keswick Road Baltimore, Maryland 21211 Ronald G. Morgan Jr., Friend 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/15/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Serviced icensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LEARY DISTAME MTHEROSCLEROTIC year Due to (or as a consequence of) OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 🗖 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner The law requires that the death certificate be executed sician and burial-tran P.O. Box 68760, attending physician for use as the burial been signed by the should be detached Division of Vital Records, has Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifice etely filled in by the funeral director.

Physician

/Medical

Examiner

Funeral

Director

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Director

Funeral

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Completed

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Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it Medical Experience must be collised as once.

Physician

/Medical

Baltimore, Maryland 21215-0036

the Maryland

Physician/Medical þ Completed Be Certification: To 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Spepk MD

00053150 Sentigo Road, Suite 110

29c. License number

29d. Date signed (Month, Day, Year) MAY14 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9650 Snakunmale

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAY 1 5 2008



ORIGINAL

State

Registrar

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2-003p	be filed within 72 hours after death with the Maryland trai Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 ☐ Yes 2XX If Yes, Give Year or Dates:	lo	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes ②CXNo	n, Mexican, Puèrto Specify:	o Rićan, etc.)	0	hite, etc. LACK			
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lan	uld b Menta rrked tic e	70	HERMAN W. BRADF	ORD			FLORE	NCE BRAD	DFORD				
a	2 should and Men is markeraumatic	•	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street a	nd Number or Ru	ıral Route Numbe	er, City or Town, State	e, Zip Code)			
Ξ	s 1 and 2 should F Health and Men Item 27 is marke other traumatic		Michael A. Boone/	Son			OODS RD.		OR MILL, M				
e e	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Demoval from State	20b. Place of Dispe	osition (Name of matory or other place	e)	Date	20c. Location - City	or Town, State			
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Balt	permit. Departn Importa any Inju		21. Signature of Funeral Service Lice	Mun	2 W	2 Name and Addres	s of Facility BROWN CO		FUNERAL H	OME P.A.			
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Ž.	requires that the een signed by th nould be detache		Part il. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use contribut	e to the cause of death?			
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DIVISION	or Atten after deat Director; in by the	Certification:	4 Homicide determined	building, et	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (Street and Number of wn, State) 3–B	Rural Route Number, Solar Circle,			
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	To the I within 2. To the I complet	Ž	29b. Signature and title of certifier			29c. License	enumber		29d. Date signed (M	lonth, Day, Year)			
			1/6/h	M.D.		RES	-000	1	MARCH 27	2008			
(0	3		30. Name and address of person who	· ·	eath (Item 23a) (Type	_	, MD 21	287					
Ì	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 3 2008	32. Registr	ar's Signature	r v		•					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 100 per fil 26 per yerb 2879 5-15-08 Hypiene 2000 amend item 100 maryland behavior health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Veal 1200AM **Physician** Joseph R. Bauer, Jr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 127 Baltimore 4900 Ritchie Hwy. Unit If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 2-16-1973 5. Social Security Number 6. Sex Funeral Days Hours Min 1**⊊** M 2□ F 35 Maryland Director 219-02-3134 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygiene. Important: if item 21 is marked other than "natural", or items 23a or 28a-f show any hujury or other traumatic event, the "Accident Exemilier must be an illustrated. Brooklyn Park 1√2 Yes 2 □ No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number unknown USA 21225 P.O. Box Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. SpecifyWhite 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bauers Elementary/Secondary (0-12) College (1-4or 5+) Custom Cabinets Cabinet Maker 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carolyn M. Sann Joseph R. Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife P.O. Box 3443 Brooklyn Park, MD 21225 Heather Bauer Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2008 Baltimore, MD Oaklawn Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD21224 21. Signature of Funeral Service bicensee 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician End Stage Multiple
Due to (or as a conse fuence of): Scierosus disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 1 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To after death. Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending within 24 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 144593 May 14th 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debarah I Morce 25 MAIN STREET REISTERSTOWN MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

P.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 P^{M} CLARA VIRGINIA BURGAN 3:05 MAY 11, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3907 PARKSIDE DR N/A BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ X Months 214-26-6195 81 FEB. 3, 1927 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show la or 28a-f sh t be notified 1 XYes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with i eaith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or ? 3907 PARKSIDE DR 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or items ledical Examiner n Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo WHITE Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3RD SEWING CLOTHIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CLARA KATHERINE MAY ARTHUR BURGAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 3907 PARKSIDE DR BALTIMORE, MD 21206 NORMA TRACEY-SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CEMETERY 5/15/08 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Sig uture of Funeral Service License MILLER-DIPPEL FUNERAL HOME, INC. 22. Name and Address of Facility 6415 BELAIR RD BALTIMORE, MD 21206 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or find it wons that caused the shock, or heart failure. Live the one cause on each line. area, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a Prisequence of): **Physician** /Medical Examiner Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, **p** pe I Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1□ Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0059388 13-08 heisman 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rover Baltimore MD 21239 Blul ,5601 Weisman 31. Date filed (Month, Day, Year) MAY 15 State 2008 Registrar

DHMH 17 Rev 1/2001

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 28b, e, I, per me g8/9,05/13/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 05 02 Ernestine Carroll 2008 8:45a. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Haven Nursing Home Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 212 F Director 61 212-48-4745 10 05 46 MD Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2213 North Dukeland Street 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3√ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Child Care Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t and 2 should be t Health and Mental Tem 27 is marked o Dave Crafton Alberta Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 Daphne Hicks-Daughter 2213 North Dukeland Street, Baltimore, permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 5/7/08 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Kich W march 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Correllac armythemieus 15 MINNED /Medical Due to (or as a consequence of): Examiner TRAUMATIC BRAIN INJURY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner APPROVED BY MEDICAL EXAMINER motor Venicle accident 11 attending physician and for use as the burial-trar Due to (or as a consequence of): ence phalo porthy ERTIFICATION Hospital or Attending Physician: The law requires that the death certificate be Ü Physician/Medical Anoxic 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diohelenmellitus, Hypotypoelism 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 4 12 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural passanger meter venuele circlest 5 Pending investigation **Unknown** M JAN 1 1977 1 ☐ Yes 2 ☑ No 2 Accident 6 Could not be 3 ☐ Suicide lo to... within 24 hours a... To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* **Roadway** 28f. Location (Street and Number or Rural Route Number, City or Town, State) Interstate 95 at Harbor Tunnel, Baltimore, MD 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

P.O. Box 68760.

Records,

Division of Vital

DHMH 17 Rev 1/2001

KNESAINM

DIE maiden chorce lane

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOESAI MO

MAY 1 3 2008

31. Date filed (Month, Day, Year)

D30494

Calonsville mo unis

51612008

Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) LOUIS

ANDREA FRINGS/ DAUGHTER 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

20b. Place of Disposition (Name of BETH EL MEMORIAL PARK

Date 20c. Location - City or Town, State 5/14/2008 RANDALLSTOWN, MD

8900 REISTERSTOWN RD. PIKESVILLE, MD., 21208

Physician /Medical Examiner

signed by the attending physicien and d be detached for use as the burial-transit

been si

certificate

safer deau....rel Director: After this cer.....

within 24 hours a

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or Attending Physician: The taw requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

or 28a-f ehow

iteme 23a

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"natural"

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Machine 2006.

other traumatic event, the Madical Examinar must be notified at

Completed by Funeral Director

Be

2

Examine

Completed by Physiclan/Medical

Be

2

Certification:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. neu Due to (or as a consequence of): Oha sequence of):

Year

Approximate Interval Between Onset and Death

Due to (or as

23d. Date of delivery Month Day

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

2 No 24a Was an

3 ☐ Probably 4 ☐ Unknown

autopsy performed? (es 2) No 1 Yes

1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes

26. Place of Death (Check only one

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

2 No 1 🗌 Yes 27. Manner of Death Natural Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

25. Was case referred to medical examiner?

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

3 DOA

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my relation death accurred.

29b. Signature and title of certifier

essecration

D41955

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

6334 Gedar Cone Columbia MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 23a, 25 per me, g879 05/13/08/hb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 3. Time or 2.2 2;30 a M Day Month **Physician** Modupe D. Fakile 04-12-2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Days 1 (Month, 3ay, Yeg/5 9 Nigeria 48 Yrs. 218-31-4838 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD Montgomery Director Silver Spring 1 □Yes 2 □ No 10e, Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 'natural', or items 23a or dical Examiner must be r 402 Calloway Court Nigeria Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Private Manager the other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi Mental I Solomon Erinle Susanah Osilesi Pages 1 and 2 should 2 and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai once. Emmanuel Fakile/Husband 402 Calloway Ct. Silver Spring,MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 Burial 2 □ Cremation 3 □ Removal from State 4-19-2008 Prince George, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Ceme. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald Taylor II Funeral III Konson 108 W. North Ave. Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer with complications /Medical noliteilai ne Due to (or as a consequence of): Examiner Severe Cardiomyopathy Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of). Congestive Heart **Failure** Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Morbid Obesity, Chest wall Wounds 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Hypertensive Cardiovascular Disease 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 ANo certificate death? 1 ☐ Yes Division or Vital 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2|| 110 2 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending Injury death. investigation 1 ∏Yes 2 ∏No 2 Accident Director: the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by or A 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D60826 4-13-2008

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshawa Gay Holy Cross Hospital 32. Registrar's Signature

Registrar

1500 Forest Glen Rd.

20910 Silver Spring, MD

Tyrone Fre	er		_
08-03404 JNK UNK		Please Type or ant in Black Indelible Ink. Ensure All Co State of Maryland / Department of Health and Menta	
		1- For State Crawar yard / Department of Fleath and Wente Registrar	Reg. No. 2008 58
Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Medical Examin	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	May 4, 2008 0738 hrs
7		2113 Orleans Street Baltimore	NA
~ Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	Torsian
Director		219-02-8847 1×M 2 F 25 Yrs. Months Days Hours	Min. Apr: 120,1983 Country) M.D.
any		Usual Residence of Decedent 10a. State 10b. County / 10c. City, Town or Location	10d. Inside City Limits
ind show a	'n	MD. N/A BATTIMORE	1 Kes 2 No
Maryle - 28a-f	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	٥	4802 FRANKFORD AVE 21200	Dt. S. FF.
eath wi	ıneral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If	Puerto Rican, etc.) White, etc.
after de	by Fun	3 Widowed 4 Divorced If Yes 2 No specify:	Specify: B/ACK.
hours and matura	ed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give king most of working life. DO NOT u	
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	LABOTER
5-00 led wit Hygien other			Name (First, Middle, Maiden Surname)
21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	14Rone Gills PA	TRICA FREEMAN
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hyglene Important: If item 27 is marked other thinjury or other traumatic event, the Med	ဥ	19a. formant's Name/Relationship (Type, Print) PATRICIA FRECMAN MOTHERS 19b. Mailing Address (Street and Number 4802 FLAT	ver or Rural Route Num er, City or Town, State, Zip Code)
Baltimore, MD oemit. Pages 1 and 2 she Department of Health and important: If item 27 is njury or other traumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
MOF Pages ent of unt: If		1 Donation 5 Other Specify: Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: About as Mcm. PL.	MAINZOOS ARBUTUS MD.
Balti permit. Departm Importa injury o	- 20	21. Sign by If Funeral Service Licensee 22. Name and Address of Facility	neval Home I m.
	Y.	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car	rdiac or respiratory arrest, shock, or heart Approximate Interv.
Physician /Medical		failure. List only one cause on each line.	Between Onset an Death
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-	'n	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):	
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Box 68760, e death certificate be the attending physic ed for use as the bur	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	23d. Date of delivery
K 68	cian	22bd. was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy Month Day Year
BOy e death the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown	
D.O. that th	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 681 ral or Attending Physician: The law requires that the death certificate death. "I Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the control of the deathed for use as the deathed f			24a. Was an 24b. Were autopsy findings availab
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Vita	8	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4	Nursing Home 5 Residence 6 ✔ Other: Scene
n of Vit ding Physic After this of funeral dire	J:T	27. Manner of Death 28a. Date of Injury 1 Natural 5 Panding FOUND: Day, Year) POUND: Day, Year) FOUND: 1 Yes 2	Subject shot
Sior Attend r death ector: by the	catic	Accident Pending Pounds	
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Back Yard	or Town, State) 2113 Orleans Street, Baltimore, MD
pspi hou y fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	ce, and due to the cause(s) and manner as stated.
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	
	Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year) May 4, 2008
7.		O.C.M.E.	IVIAY 4, 2000
\emptyset		 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120 	01
		31. Date filed (Month, Day, Year) 32. Digistrar's Signature	
Registr	rar	MAY 1 5 2008 Keen K Small	

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08-03546

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John J. Grace		1- For State	tate of Marylar		ment of <i>icate of</i>		Mental Hy		g. No. 200	18 1586
Physicia	n/	1. Decedent's Name (First, Mid				-		2. Date of Death		3. Time of Death
Medical Examir	ner	John J. Grace						May 9, 200	8	1204 hrs
_		4a. Facility Name (if not institut St. Agnes Hospital		per)		b. City, Town, or L Baltimore	ocation of Death		4c. County of Deat	
Funeral Director		5. Social Security Number 216-72-3748	6. Sex 7	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1	9. Bi Forei 30, 1958	
any		Usual Residence of Decedent 10a. State 10b, County	,	10c. City, To	wn or Locatio	on				10d. Inside City Limits
*	Ļ		imore			e Highla	inds			1 Yes 2 No
te Maryland or 28a-f show	Director	10e. Street and Number				10f. Zip Code	uidb	10	g. Citizen of What Cou	intry?
the N	盲	3015 New Yor	k Ave.			212	.27		USA	
th with	Funeral	11. Marital Status 1 X Never Married 2		dent Ever in U.S.		Decedent of Hisp es, specify Cuban,			14. Race - Amer White, etc.	rican Indian, Black,
ter dea	교		1 Yes	2 X No		X	specify:	,	Specify:	White
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6 n 72 hc an "na icat Ex	ete	Elementary/Secondary (0-12) College (1-4	or 5+)	during mo	st of working life. I	DO NOT use retire	ed)		
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be C	John Anthony	· ·			1	Mary Lo			
21 hould b ad Mer is mar	은	19a. Informant's Name/Relation					and Number or Ru	ural Route Numl	ber, City or Town, State	e, Zip Code)
MD and 2 sho salth and em 27 is raumati		William L. Gr	ace, brothe			th Ave.	Lansdow	me, MD.	21227 20c. Location - City o	Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crematic	n 3 Removal from	State Mead	natory or oth OWLIDE	er place) ge Memori	al Park	05-13-0	8 Elkridg	
Baltin permit. P Departme Importan injury or	1	4 Donation 5 Other 3 21. Signature of Funeral Service				ibiosédifu				, - ,
	4	23a. Part I. Enter the disease, of	92		13	28 Sulph	ur Sprin	g Rd.	Arbutus, M	D. 21227
Physician /Medical		failure. List only one caus	e on each line.					respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
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Sox 6876(death certificate e attending phy:	Ž	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, ou	tcome of pregnan	су	al death 3	Ectopic pregnan	icy	23d. Date of deliver	ry Day Year
Box 687 death certifica the attending p	sicia	past 12 months? 1 Yes 2 No 9 Ur	4 Pregnar	t at time of death	- =	er (Specify)				,
O. Bo	P	Part II. Other significant condi	9 Unknow		ting in the ur	nderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The faw requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	d b							1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
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/iSic	lica	2 Accident Inve	estigation 28e. Place of		NK , farm, street	, factory, office but	ilding, etc. 2			ural Route Number, City
Divisi pital or Att ours after d neral Direct filled in by	Certification:	4 Homicide dete	ermined (Specify)	hame				or Town, St 3015 New	_{ate)} York Ave. Bal	timore, MD
0 = 5 5	Medical		hysician: To the best of miner: On the basis of and manner state	examination and/o						
	ž	29b. Signature and title of certifi				29c. License	OCME		29d. Date signed (Mo	onth, Day,Year)
Ø		Thoday M	King TI	3 mis		O.C.M	.E. 30		May 10, 2008	
		 Name and address of person Theodore M. King, Jr 		of death (Item 23a Medical Exa	,	111 Penn Stre	et, Baltimore.	, MD 21201		
Sta		31. Date filed (Month, Day, Year)	32 Regis	strar's Signature	1	et .				
Registr	ar	MAY 15	2008	is sto	1900					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2000 Vernon Given /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 236-22-8718 85 Director 02/04/1923 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 Windjammer Road 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [AYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Completed by 3XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Tree Surgeon Horticulture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Roy Given 2 Pearl Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daugh-Pages 1 and 2 tment of Health 2 1 and 2 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Mrs. Charlene Heimberg 802 Windjammer Road, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ŽXXCremation 3 ☐ Removal from State Chesapeake Cremation 05/14/2008 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation SErvices 21061 MO1357 ancus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chrom L 565 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 9□Unknown signed by the at d be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy perform this certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

land 21215-0036

Mary

3altimore.

State Registrar 29b. Signature

and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type_Print)

togetal Davie

29c. License number

29d. Date signed (Month, Day, Year) May 12 2008

MD. 21061

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

IHOMAS

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32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MilitAND

29c. License number

0 36207

29d. Date signed (Month, Day, Year)

May 2, 2008

			State of Maryland /			lental Hygier	ne No2008	15866
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Death	Reg. I	40Z U U O	3. Time of Death
	Physicia /Medic		RHONA JEÁN GOLDSTE			Month MAY 1	2 2008	8:37PM
	Examin	er	4a. Facility Name (If not institution, give street and number) S/NAi +(OSP)/TAZ OF BALTIMO		r Location of Death MORE	city	4c. County of Deat N/A	h
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 24 Hrs. Hours Min.	8 Date of Rinth	9 Birt	hplace (State or Foreign
ď.	Director		219-28-5704 1□M 2ĀF 76	Yrs. Worth's Days	Tiodis (VIII).	10/07/193	31	PA
	land ow			own or Location				10d. Inside City Limits
:	e Mary a-f sh tified	ctor	MD BALTIMORE	BALTIMORE				1 ☐ Yes 2 🖺 No
	n with the 23a or 28 st be not	Funeral Director	1 GRISTMILL COURT, #105	10f. Zip Code	21208	10g. (Citizen of What Co USA	ountry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Important: If liem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of F If Yes, specify Cub. 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
5	72 ho "natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of worki	ing 16b.	. Kind of Business/	Industry
4	within ene. than he Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	SALES	a)		CLOTHING	3
2 :	al Hyg other vent, t	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
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, Ivial	and 2 sh ealth and n 27 is m er traum		MICHAEL GOLDSTEIN / SON 1	9b. Mailing Address (Street L201 N.GARFIE	LD ST.,AP	T.517 ARI	LINGTON,	Zip Code) VA 22201
5	Pages 1 and nent of Health nt; If item 27 iry or other ti		1¥ Buriai 2 □ Cremation 3 ★ Removal from State	e of Disposition (Name of etery, crematory or other place			Location - City or	
,	urtmen urtant; urtant; injury		4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service (Aconse)	ISRAEL CEMET		/2008 CO L LEVINSON	DATESVILI	,
3	Departing any Ir) S S	8900 REIST			VILLE, MI	
H	NEWS.		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dyli	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		SEPSIS	ce of):				2 DA45
0.	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ce of):				
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5	tificate ig phy as the	ledic	0.					
	o the hospital or Attending Prlysician: within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de: 4 □ Pregnant at time of death	ath 3 ☐ Ectopic pregnanc	у		23d. Date of del Month	livery Day Year
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	ine law ate has be	Completed by	CEREBRO VASCULAR HYPERTENSION	ACCIDENT		24a. Was an autopsy performed 1 Yes 2	? death?	utopsy findings available completion of cause of 2 1 No
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5	naing ath. r: Afte e fune	ation	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		rk? Yes 2 □ No		. ,	
2	al or Arte after dea Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office		28f. Location (Street City or Town, St	and Number or Reate)	ural Route Number,
	or the hospital or Attending Privality 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the ti and/or investigation, in my	me, date and place, opinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and du	s stated. e to the cause(s)
-	To the comp	Me	29b. Signature and title of certifier	29c. Licens			Date signed (Moni	
	20		30. Name and address of person who completed cause of death (Item 23.	a) (Type, Print)	INAI HO	OSPITAL I	OF BA	, 2008 LTIMORE
i vy	Sta Registr		31. Date filed (Month, Day, Year) 32. Resistrar's Signature MAY 1 5 2008	1 Sperter	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9 Eleanor Parkell Hogate /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9. 4/18/1914 New Jersey Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 1 94 Yrs. Director 154-22-3562 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event, the Medical Examiner must be reany injury or other traumatic event. U.S.A. 709 Deering Road 21122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 NNO 1 ☐ Yes 2 ☑ No Specify 2 Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) Retail Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Carpenter Parkell Lvdia Erb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8202 Edwin Raynor Blvd., Pasadena, MD 21122 Wilbert Conover, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ⊓ent of F 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 05/13/08 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem Crownsville, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licenses 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ceretoro Vascorlar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director: Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 WW person who completed cause of death (Item 23a) (Type, Print) Name and addr intre

State Registrar 31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

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Con x		4a. Facility Name (if not institution, g New Germany Road @ \			4	b. City, Town, Savage R		of Death		4c. County o Garrett	f Death	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	4297 Barkhill I	Poad			2179			"	US		,,
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and 2 sho eafth and tem 27 is	L	20a. Method of Disposition	111 5011			ition (Name of		Date		20c. Location -	1784 City or To	own, State
Baltimore, permit. Pages I ar Department of He Important: If He njury or other tr	-	1 Burial 2 X Cremation 3		alc	matory or oth	ner place) matory,	Tno	5/1///2	วกกุด	Poltin	0000	MD
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Division tal or Attendii us after death. al Director: A	Certification:	3 X Suicide 6 Could no	ot be 28e. Place of Ir	njury - At home	e, farm, stre	et, factory, offic		tc. 28f.	Location (S	Street and Numb	er or Rura	al Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	16 L	(Check only one) 2 Medical Examin	ician: To the best of m er:On the basis of exa	y knowledge, mination and/	death occur or investigat	red at the time, tion, in my opin	, date and pla ion, death o	ace, and due to courred at the	to the caus time, date	e(s) and manner and place, and d	as stated Jue to the	d. cause(s)
To To con.	활	29b. Signature and title of certifier	and manner stated.				ense number			29d. Date sign		

State 31. Date filed (Month) Registrar OCME 2006

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

May 13, 2008

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 0900 PM SAMVEL HARDESTER 03 2008 05 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE CITY BALTIMBRE JOHNS HOPICIUS BUYVIEW MODICAL CENTOR 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) Days Hours 1 ☐ M 2 ☐ F December 8 1916 Baltimore, Maryland 218 10 7203 91 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Baltimore City Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 4803 Strathdale Road 21206 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: WW II White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yard Foreman Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel D Hardester Sr Bertha Pertine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6143 Parkway Drive Baltimore, Maryland 21212 Carol M Karwacki 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Mem. Park May 6:2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory irrest, Cothou BOOLY Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACEREBRAL HEMORRIAGE Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMPLES 2 DAYS FALL AT HOME Equentiany list conuntors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown PNEWMOTHORAX 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an SCALP LACERATIONS autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

Physician /Medical **Examiner** Examine

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

show

ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other treasment.

Maryland 21215-0036

Baltimore,

O. Box 68760

Records,

or Vital

Physician/Medical

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Completed

Be

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Certification:

Medical

After

Division Hospital or Attending completely filled in by the To the Hospital within 24 hours a To the Funeral L 2+1 State Registrar 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 05/01/68 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

HOME

28b. Time of Injury 10:00 AM

28c. Injury at Work? 1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

FALL

28f. Location (Street and Number or Rural Route Number, City or Town, State) 4803 STRATHMORE RD, BAKTIMORE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and title of certifier Kerm B.

29c. License number H31298 29d. Date signed (Month, Day, Year) 05/03/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVE, BAUTIMORE, MD 21224 KEVIN B. GEROUD, DO,

31. Date filed (Month, Day, Year) MAY 1 5 2008



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 12, **Physician** 12:40 P M 2008 William Η. Hall /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 304 Valdene Court Baltimore Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/14/1917 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □XM 2 □ F 91 219-26-5165 Cananda Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. The Medical Experience. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Timonium 1 TYes 2 TNO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 304 Valdene Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Tea Taster Elementary/Secondary (0-12) College (1-4or 5+) American Classic Tea 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Howarth Harry Hall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) American Classic Tea Lane Wadmalaw Island, SC William B. Hall / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State ′15/2008 Towson, Maryland Hilltop Serv. Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland 21204 Towson, Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIAL ARRIVY THEM, A **Physician** MINUTSS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 WUnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an this certificate has autopsy 1□ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 Yes _ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) P 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural (Month, Day Year) Injury 5 Pending investigation М 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1m02 E 21 uch 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 8, Mary Jane Hagin **2008** 9:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Manor Care Falls Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 18 , 1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XX Months Mary land 1 □ M 66 216-38-4824 Director Usual Residence of Decedent la or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits N/A Baltimore Maryland 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3451 Keswick Road 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Never Married 2 Married 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: White 1 ☐ Yes XX No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Envelope Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Haqin Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Hagin, Sr. 3451 Keswick Road, Baltimore, Maryland 21211 Son 20b. Place of Disposition (Name of cemetery, crematory or other place Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/12/2008 Fullerton, Maryland 21. Sign dur of Funeral Service Lig ²² Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland Ing. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYPERTENSIVE CARDIOVASULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an has autopsy performe certificate l 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be determined 124 hours after dea 16 Funeral Directo bletely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSTOWN, 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

			State of Ma 1 - State Amend PIline a per MD 0879	aryland / Depa 5/15/08 TT _{Cel}	artment of Health and rtificate of Death	Mental Hy	giene Reg. No. 200	8 15872
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Carl L.		Jackson	Month 05	O7 2008	
40	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat	h	4c. County of Dea	ath
pp.			6800 Liberty Road Apt		Baltimore			
	Funeral Director		1 1 1 M 2 □ E	(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		v, Year) C	irthplace (State or Foreign Country)
			Usual Residence of Decedent	34		07 13	33	MD
	how how	_	10a. State 10b. County	10c. City, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
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	ath w		6800 Liberty Road Apt		21207		U.S.	
	hours after death with the Maryland tural", or Items 23a or 28a-f show al Evaminar must be notified at	Funeral	11. Marital Status 12. Was Decedent I Armed Forces?	Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	rs aft	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give If Yes, Give Year or Dates:	10	☐Yes X☐No Specify:		Specify: B	lack
9	2 hou atura	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupation		16b. Kind of Business	
215	in 72 an "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done during most of wor DO NOT use retired)	king	Tob. Tana of Bacillook	S. III daosi y
21	d with	Com	12th grade na		ervisor		Lock Heed	d Martin
pq	be file tai Hy d oth	Be (17. Father's Name (First, Middle, Last)	_	18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
yla	Ment Ment arkec	ဥ	Earl Jackson		Dorothy	Jacks	on	
Лaг	2 shk and Is m raum		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street and Number or Ru	ıral Route Numbe	er, City or Town, State,	Zip Code)
	f and Health		Dorothy Jackson-Mother		Fordleigh Roa			
altimore,	iges nt of l		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State	1	sition (Name of natory or other place)	Date	20c. Location - City o	·
Ξij	it. Pa rtmei rtant njury		4 ☐ Donation 5 ☐ Other (Specify)		orial Park 5/1	15/08	Woodlawn	, Md
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Evanting must be notified at once.		21. Signature of Funeral Service Licensee	Ma	Name and Address of Facility			01015
			23a Part 1 Enter the disease accomplications that caused	the death. De not entr	68h wabash ave,	Baltı	more, Md	21215
Z			23a. Part 1. Enter the disease, o complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final	Myocardial.	in arction	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Sales .	Physician / /Medical		disease or condition resulting in death)	pica Pox	1 Kx spristor	THRE	()	
1	Examiner		Due to (or as	consequence of):	تدلاره ع دن	/		
		ē	Sequentially list conditions, b. Due to (or as a	Consequence of):	3047.3			
	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	, ,				
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8760,	ficate be executed physician and s the burial-transit	dical	d					
89	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burrial-transit	0	IE EEMALE.					
Вох	eath certifications attending postering for use as	an/l	IF FEMALE: 23b. Was decedent pregnant in the pact 12 months? 1 ☐ Live birth		Ectopic pregnancy		23d. Date of de	
о Ш	e dea the at	sici	1 Yes 2 No 4 Pregnant at		Other (specify)		Month	Day Year
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ä	has has ge 2 s	du l	DTII (20.52 140)	a rec rup	ertyphy	24a. Was a	sy prior to	utopsy findings available completion of cause of
g	sician: The certificate h rector, page		Mistory of DV) der i	1200 My Contos	perfor 1 □ Yes	med? death?	
Vital	sicia certi irecto	Be	25. Was case referred to medi 1 examiner? 1 Yes 2 No Hospital: 1 Inpatie		Othory	th (Check only or		
Division of	Physer this eral dir	٤	27. Manner Death 28a. Date of Injur	nt 2 ER/Outpatient	3 DOA 4 I Nursing H		ence 6 Other (Spe	ecify)
o	nding F tth. :: After e funera	ţ	1 ☑ Matural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No		on injury occurred	
Vis	Atte	iţi	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, stre	et, factory, office	28f. Location (S	treet and Number or Fi	Pural Route Number,
ō	tal or 's afte al Dir ed in	Certification:	4 Homicide Solermined building, etc	(Specify)		City or Tow	n, State)	
			29a. Certifier (Check only 2 Medical Examiner: On the basis of	f my knowledge, death	occurred at the time, date and place	, and due to the	cause(s) and manner a	as stated.
	the hin 24 the F	Medical	and manner star	ed.		Tou at the title, (впо рівсе, апо du	e to trie dause(s)
	Vit Vit	2	29b. Signature and title of certifier	· Mr	29c. License number		29d. Date signed (Mon	
	$ \sim$ $ $		what I must	UIIV	134610		5/08/20	08
	X		30. Name and address of person who completed cause dide	ath (Item 23a) (Type, P	(rint) { 33rd Jr 4	130. A	1 510- 01-	0- N 2 : 2 : C
	Stat	0	31. Date filed (Month, Day, Year)	's Signature	1 3310 31 T	1-5,00	MINNE	175016
	Registra		31. Date filed (Month, Day, Year) MAY 1 5 2008 Registra	The Page				

DHMH 17 Rev 1/2001

Physician /Medical Examiner

Funeral Director 3a or 28a-f show t be notified at ms 23a or items "natural", or iten edical Examiner

filed within 72 hours after death with the Maryland other traumatic event, the Medical s 1 and 2 should be filed wi f Health and Mental Hygien Item 27 is marked other th permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other

Maryland 21215-0036

altimore,

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi the attending physician and cate has been signed by page 2 should be detach

Division or Vital Records, P.O. Box 68760,

After this 24 hours after deathe Funeral Director: To the 0

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Arlene 552 P Ohnson 05-09-2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Year) 6. Sex 8. Date of Birth (Month, Day, 6 25 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 1 ☐ M 2 🔀 F Yrs. 217-40-3465 66 Maryland Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Darlington 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2506 Shuresville Rd 21034 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 College (1-4or 5+) Elementary/Secondary (0-12) Juvenile Justice Criminal Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Harrison Hazel Terry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard N. Johnson Jr. (Husband) 2506 Shuresville Rd Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dublin Southern Cem. 05-14-2008 | Darlington, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a CONGESTIVE HEART FAILURE Due to (or as a consequence of): RDIDMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETES MELLI TUS Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 5 ■ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29c. License number M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registrar's Signature

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rin Casey Johr		otato of Marylana / Dopartmont of /				0 1507			
		1- For State Certificate of D	eath		. No. 200				
Physicia ledical Exami	.111/4	1. Decedent's Name (First, Middle,Last) Erin Casey Johnson		2. Date of Death Month May 5, 200	Day Year	3. Time of Death 1829 hrs			
			City, Town, or Location of Death Darlington		4c. County of Death Harford				
Funeral Director		216 21 0/17	If Under 1 Year If Under 24Hrs Months Days Hours Min	8. Date of Birth	Eoroige	place (State or htry) MD			
		Usual Residence of Decedent		0, 1, 1					
nd show any ice.	_	10a. State 10b. County 10c. City, Town or Location 10d. MD Harford Darlin	ngton			10d. Inside City Limits 1 Yes 2 X No			
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	0f. Zip Code	100	g. Citizen of What Count	ry?			
ith the day		2506 Shuresville Rd	21034		USA				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner myst be notified at once.	1 Yes 2 X No 1 Yes 2 X No specify: Specify: Wh:								
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	S	17. Father's Name (First, Middle, Last)		e (First, Middle, M					
121 d be fi lental arked	Howard N. Johnson Marlene K. Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C								
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ore, MD 2 ges I and 2 shou t of Health and N : If item 27 is rether traumatic		20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery,	Date	20c. Location - City or	_			
MOF Pages lent of int: If		1 X Burial 2 Cremation 3 Removal from State Crematory or other 4 Donation 5 Other Specify: Dublin Sou		-142008	Darlingtor	, MD			
Baltimore, permit. Pages I at Department of Het Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Nan	ne and Address of Facility Sch	nimunek F	uneral Home	of BelAir			
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/Medical -xaminer		Immediate Cause (Final disease or condition resulting in death) a. Complications of remote per or condition resulting in death) Due to (or as a consequence of):	riventricular leuk	<u>comalacia</u>		Death			
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executed an and al - transit	Щ	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
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8760 ificate ng phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the constant 2 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregn	ancy	23d. Date of delivery Month	ay Year			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Me	past 12 months:	(Specify)						
O. B of the de lby the		Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tot	bacco use contribute to	he cause of death?			
ords, P.O. w requires that it is been signed by should be detact	d by	<u>Hypertension</u>		1 Yes		ably 4 🗸 Unknown			
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should t	Completed			24a. Was a autops perform	sy prior to c	opsy findings available ompletion of cause of			
tal Rec cian: The l certificate l ector, page	Con		OO Direct Death (Oh and	1 ✓ Yes 2		s 2 No			
'ital sician: is certi lirector	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient :	26.Place of Death (Check		Residence 6 🗸 Other	Scene			
n of Vital Rec ling Physician: The After this certificate funeral director, page	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		28d. Describe h	ow injury occurred				
tendin death.	atio	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined (Specify)	factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Ru tate)	al Route Number, City			
Hospi 24 hou F Funer etely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	d at the time, date and place, an	d due to the cause	e(s) and manner as state	ed.			
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		at the time, date a					
	≥	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Moi May 6, 2008	un, Day, rear)			
		30. Name and address of person who completed cause of death (Item 23a)			, , , =====	··			
8	2_3	Ana Rubio MD. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 2120)1					
S Regis	ate	31. Date filed (Month, Day, Year) MAY 1 5 2008 32 Registrar's Signatus	E Company						

			For State Registrar	State of M	larylar		rtment of l		Mental Hy	/giene 2 0 0 {	3 15875
	Physici	an	1. Decedent's Name (First, Middle SALVAC)		AVI	ER			2. Date of D	eath Day Year	3. Time of Death
and.	/Medio Examir		4a. Facility Name (If not institution	, give street and number	r)	-	**	or Location of De	7	4c. County of Dea	4 55
	Funeral		,		ge (In yrs.	last birthday)	If Under 1 Year Months Days	ALLS TI	rs. 8. Date of Bi	irth 9. Bin	thplace (State or Foreign
	Director		213-81-6992 Usual Residence of Decedent	1□ M 2√ F	71	Yrs.			Nov.1		ilippines
	Marylar I show	tor	Maryland Bal	timore	10c. Ci	ty, Town or Loc Pikes					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the a or 28a be noti	Directo	10e. Street and Number		_		10f. Zip Code	000		10g. Citizen of What Co	•
920	72 hours after death with the Maryland natural", or Items 23a or 28a-f show diest Examinat roust be notified at	Completed by Funeral	3 Stock Mill 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	t Ever in U ? [No	if	212 Vas Decedent of P Yes, specify Cub	Hispanic Origin? an, Mexican, Pue	(Specify Yes or N erto Rican, etc.)		erican Indian, te, etc.
15-0036	"natural"; "natural"; edien Exe	leted	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Deced	ent's Usual Occu kind of work done OO NOT use retire	oation during most of w	orking	16b. Kind of Business	/Industry
2121	ed withii lygiene. ner than it, the M	Comp	Elementary/Secondary (0-12) 10th grade	College (1-4or	5+)	Homem				Private H	ome
/land	uld be fil Mental F irked otl	To Be	17. Father's Name (First, Middle, L Emiliano Ramo	•				Estelt	ame (First, Middle a Comac	e, Maiden Surname) lor	
, Mar)	and 2 sho eaith and I n 27 is ma er trauma		19a. Informant's Name/Relationsh Materesa J. (ip (Type. Print) Georges/Da	aught	19b. Mailing	g Address (Street 3 Stoo	and Number of K Mill A	Rural Route Numb Road pt.J	ber, City or Town, State, Pikesvill	Zip Code) e, Md 21208
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		He I	Place of Dispos cemetery, crem ritage	ition (Name of atory or other pla Park	The For	Date t 4/08	20c. Location - City or Taguig Me	Town, State etro Manila ppines
Balt	permit. Depart Import any inj		21. Signature Funeral Service L	icensee			Name and Address	ess of Facility	hatman.	-Harris Fu Baltimore,	neralhome
			23a. Pari 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that cause	ed the deat line.	h. Do not ente	er the mode of dyi	ng, such as card	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	s a conseq		LESK	ML H	EMORI	PHAGE	
		ner	Sequentially list conditions, if any, loading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a our seq	uerice ofy:					
0,	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	s a conseq	uence of):					
68760,	ficate be physicial from the bu	edical		d							
.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3 🗆	Ectopic pregnand Other (specify) _	су		23d. Date of de Month	elivery Day Year
rds, P.	w requires that the de- been signed by the a should be detached fo	þ	Part II. Other significant condition	ns contributing to death	but not res	ulting in the un	derlying cause giv	en in Part I.		tobacco use contribute t Yes 2 ☐ No 3 ☐ F	. /
al Records,	sician: The law re certificate has be irector, page 2 sho	Completed					-		24a. Was auto perf 1 □ Yes	ppsy prior to death?	utopsy findings available completion of cause of s 2 ENo
of Vital	ysician iis certifii director,	o Be	25. Was case referred to edical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆	ER/Outpatient	3 □ DOA Oth		eath (Check only Home 5 ☐ Res	one) idence 6 □Other (Spe	acify)
o uoi	ng ifte	ation: 1	27. Mann of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Date)		28b. Time of Injury	28c. Inju Wor	ry at		how injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 6 Could no determin	28e. Place of In building, e	jury - At ho tc. <i>(Specii</i>	ome, farm, stre	et, factory, office		28f. Location City or To	(Street and Number or R wn, State)	ural Route Number,
	e Hospit 124 hours e Funera letely fille	Medical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best examiner: On the basis and manner s	of examina	owledge, death ation and/or inv	occurred at the ti estigation, in my	me, date and pla opinion, death oc	ice, and due to the curred at the time	e cause(s) and manner a , date and place, and du	s stated. e to the cause(s)
	To th withir Comp	Me	29b. Signature and title of certifier	- 84	7		29c. Licens	o	7	29d. Date signed (Mon	_
	in.		30. Name and address of person w			n 23a) (Type, P		5733			2008
	う Sta	te	31. Date filed (Month, Day, Year)	A V 1 M 0	/	HC iture	SALT	0. 110	2113	٥	
	Registr	ar	MAY 15	2008	for s	es Me	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Johnson Douglas Keith 9 2008 8:30 A.M May /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lochern Augsburg Luthern Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1₽M 2□F Days Hours 225-20-9140 89 1918 Virginia Director Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore N/A Maryland 1 XYes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 3811 W. Coldspring Lane 21215 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Mary No. 1 No. 1 Yes, Give Year or Dates: 1942 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Black Baltimore, Maryland 21215-0036 þ 1945 3 □XVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) 9th grade College (1-4or 5+) Clerk Administration 18 Mother's Name (First Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Bucham Walen Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Joyn, State Zip Code) r 1035 Flagtree Lane Pikesviile, Md 21208 19a. Informant's Name/Relationship (Type. Print) Daughter Cassandra Johnson/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)

Garrison Forest Vet. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md 4 Donation 5 Dother (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 21. Signature of Funeral Service Licensee, 5240 Reisterstown Rd Baltimore, Maryland aris 21215 Approximate and. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart milure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Dunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performe Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: To the Hospitar C.
within 24 hours after death.

To the Funeral Director; After this c 3□ DOA 1 Tyes 2 ER/Outpatient 4 Nursing Home 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 128595 sulle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 ALCHANI

State Registrar

31. Date filed (Month, Day, Year)
MAY 1 5 2008

32. Registrar's Signature

Aprile

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARGARET Year 38 /Medical APP MAY 9 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death S CHAIS HOPKINS BAYLIEU MEDICAL CENTER N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday, Funeral Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours Yrs. Director 213-09-7025 88 10/10/1919 MD Usual Residence of Decedent r 28a-f show notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 TYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 5927 EURITH AVE Funeral 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Pages 1 and 2 should be filed vent of Health and Mental Hygie HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILTON JACOBS GERTRUDE FAGHEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY JONES-DAUGHTER 5927 EURITH AVE BALTIMORE, MD 21206 Department of Heal Important: If Item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **METRO** 5/13/08 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 . I ter the diseas , or heat failure t complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a art1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIO PULMORNARY /Medical Due to (or as a consequence of): Examiner UNDERSIS Sequentially list conditions, if any leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WEEK Examiner The law requires that the death certificate be executed burial-trar INEUMONIA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown DISENSE page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1∐ Yes 2 **X** No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 🗌 No Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streef and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier ို့ 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar ROMSAI

31. Date filed (Mo

DHMH 17 Rev 1/2001

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egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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GASTERN AVENUE BALTIMAZE

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:00 2008 /Medical 4c. County of Death 4a. Facility Name If not institution, give street and number, 4b. City. Town, or Location of Death Examiner If Under 1 Year N/A mor 8. Date of Birth (Month, Day, Ye. 3/2/1914 5. Social Security Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 □ Year) Hours Min 213-96-8001 94 GRÉECE Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show at Examiner must be notifled 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 725 Umbra Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic event, the Media once. Elementary/Secondary (0-12) 7 th College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VASILIOS SAKELIS SOPHIA MASTROMANOLIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOPHIA HOUVARDAS- GRANDDAUGHTER 725 UMBRA ST. BALTIMORE, MD 21224 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAWN 5/15/08 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE BALTIMORE, MD 21224 23a Part . Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** hour /Medical Due to (or as a consequence of): Examiner emi 9 Sequentially list conditions, if any, leading to minimum acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the e attending p Ses IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 Ves 2 No the n signed by th 1 be ਰਕਾ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Honknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe certificate 2□No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 patient ဥ 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After Certification: 28d. Describe how injury occurred Division (Month, Day 5 Pending investigation 1 Tes 2 🗆 No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

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State Registrar

DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

05 31. Date filed (Month, Day, Year) pegistrar's Signature

, Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene a Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician PAULINE M. LANGLEY 2008 nai /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deat Town, or Location of Death Examiner LOSE 0 If Under 1 Year | If Under 24 Hrs. Min. Sex yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 21 F 85 215 16 6296 Director 11/14/1922 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes Ž∏No Director MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8063 ROSLYN AVE 21237 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo 1 ☐ Yes 2 ☐ No Specify WHITE Completed by 3 Widowed 4 Divorced Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **DMV** 0 TITLE DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Be 1 and 2 should be MAYNARD BEHLER 2 GRACE TRACY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN CHANDLER/GRANDSON 8063 ROSLYN AVE ROSEDALE, Department of Health Important: If item 27 any injury or other tr MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 5/15/08 BALTIMORE, MD CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) signed by the attending physician the detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performed? Yes 2 No this certificate 1∐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes after death. 2 Accident 2 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

se of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death A Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30, 2008 **Physician** pril Aaron Rameses Lockhart /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Washing Tow 5. Social Security Number Year | If Under 24 If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Days 237-61-6999 1 X M 2 □ F Director 06/19/1977 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ft. Washington MD 1X Yes 2 □ No Director P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a odleal Examiner must b 20744 1012 Palmer Rd. Unit 8 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 Ho Specify:Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Metro Statistician the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernie Reaux 2 Bashie Daniels 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 11860 Oak Manor Drive, Waldorf, MD 20601 Bashie Lockhart-Neal/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale PK. Crem 5/14/08 Riverdale,Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral 108 W. North Ave. Baltimore, MD 21201 21. 9 gnature of Runeral Service Licensee. 23a. Part1. Enter the disease, or complications that vused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6 cershot wound to **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was ...
autopsy
performed?
Yes 24 No page 2 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5107 him 5 clf in head 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury Agril 30 mos 1 ☐ Yes 2 ☑ No 2325 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death the Funeral Director: filled in by

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier (Check only one)

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To

32 Registrar's Signa

State Registrar

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home

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fb 8379 5-15-08 to State of Maryland Abepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** ŽÖÖ8 Linda Marie Miller 9:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 256 Asbury Rd. Pasadena Anne Arundel Social Security Number 214-50-1503 7. Age (In yrs. last birthday) 58 Yrs. Birthplace (State or Foreign 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 2X F Months Hours 1071871949 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits MD Anne Arundel **Funeral Director** Pasadena 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 256 Asbury Rd. 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ Specify: Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Mary Makelheny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B. Miller - husband 256 Asbury Rd., Pasadena, Md 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 05/12/2008 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) New Cathedral Cem. 22. Name and Address of Facility Ambrose Funeral Home of Lansdown 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Rd., Lansdowne, Md 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORONAR 99 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner puls to for as a consequence off sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the uncompared to the significant conditions. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2.27No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA J₀ 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1☐ Yes 2☐ No within 24 hours after death To the Funeral Director; 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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			1 - For Amend #8, 10e	State of Ne, perFh, G879	/laryland 5/22/08	d / Depa	artment of H	lealth a Death	and Menta	Il Hygier Reg. I	ne No. 200	0 15005
	Physici		1. Decedent's Name (First, Middle Dorothy M. Mur						Mo	e of Death	Day Year 2008	3. Time of Death 2:10 A M
	/Medic Examir	- 20 1	4a. Facility Name (If not institution Frederick Vil	n. aive street and numbe	r) H om e		4b. City, Town, or Catonsvi		of Death		4c. County of Dea	ore
	uneral irector		5. Social Security Number 212-03-7884 Usual Residence of Decedent	6. Sex 7. Æ 1 □ M 2√2 F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date (Mo	e of Birth 12 onth, Day, Yei • 9, 1	/8/1918 9. Bir 91 8 Ma	thplace (State or Foreign buntry) ryland
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	3a or 28a-f show it be notified at	I Director	10a. State 10b. County Maryland Bal	timore 8 Frederick Rd.	C	, Town or Lo Catons	ville 10f. Zip Code	228		10g.	Citizen of What Co	10d. Inside City Limits 1 □ Yes Z□ No ountry?
-0036 hours after death	d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces ried 1 Yes 22	Ž _{No}	16a. Deced	Was Decedent of Hi f Yes, specify Cuba I Yes 2 No	ispanic Ori an, Mexicar Specify:			14. Race - Ame Black, Whit	e, etc. hite
Maryland 21215-0036 Id 2 should be filed within 72 hours af Ith and Mental Hygiene.	er than "na t, the Medic	Completed	(Specify only highe Elementary/Secondary (0-12)	College (1-4o	r 5+)	(Give life. L	kind of work done of the NOT use retired the NOT use retired to the NOT use return to the NOT use retired to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to the NOT use return to t	during mosi	-		Own H	•
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	f item 27 is marked or r other traumatic eve		Virginia Timmi: 20a. Method of Disposition	,		341	18 Tyler 1			City,		42
Bag ent	# of		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	• Cre	Stlaw ardens	ratMembrila -	1	5-1/-200	OS Mo	rriottor	:11a MD
Balti permit. I Departm	any		23a, Part1, Enter the disease, or	r complications that cause	ed the death.		Name and Addres	hur S	pring Ro	d., Ar	ral Home butus, M	D_21227 Approximate
A	sician edical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	line. O (4)	dial		tion	•	,		Interval Between Onset and Death
	ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a conseque							
the death certificat	To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal of	death 3	Ectopic pregnancy				23d. Date of del Month	ivery Day Year
The law requires that the	en signed	by	Part II. Other significant condition	1	but not result	ting in the ur	derlying cause give	en in Part I.	236			the cause of death?
The law re	cate has be	Completed								a. Was an autopsy performed? Yes 2	prior to death?	topsy findings available completion of cause of
I OF VILLAI ng Physician: T	ter this certifi neral director	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpat 28a. Date of In	iury 2	R/Outpatient 28b. Time of Injury	3 DOA Othe	er: 4 🗷 Nu		Residence	6 □Other (Spe	cify)
To the Hospital or Attending Physician: within 24 hours after death.	Director: Al	Certification:	1 Natural 5 Pendin investig 3 Suicide 6 Could r 4 Homicide determ	pation not be 28e. Place of in		ne, farm, stre		Yes 2 □ N	28f. Loca	ation (Street or Town, Sta	and Number or Ru ate)	ıral Route Number,
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To tl	COM	Ž	29b. Signature and title of certifier	11/11/	M.D.		29c. License	365	-	1	Date signed (Month	2 2
	9		30 Name and address of person	who completed cause of	death (Item 2	23a) (Type, F	Print) white Rd	, # 2	oz, Bal	ltimor	·, MO 2	1228
F	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 5 2	.008 22. Regist	trar's Signatu	dos.	le le					

DHMH 17 Rev 1/2001

08-03588 Myrtle Dutton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2308 hrs May 10, 2008 Medical Examiner Elizabeth Mack-Dutton Myrtle 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Sinai Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Foreign Country) Months Days Hours Min 08 16 40 SC Director -68- 215-40-4350 1 M 2 X F 67 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County ì 10a State 1 X Yes 2 No items 23a or 28a-f show ust be notified at once. Baltimore NA MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21215 U.S.A. 3409 Lynchester Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12 Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 x No Yes Black Specify If Yes, Give Year Yes 2 X No specify: Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Churches Music Teacher 5yrs+ 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lelia Coleman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
73114
73114
731000 Be Silas James Mack 19a. Informant's Name/Relationship (Type, Print) عر ع404 وا 20c. Location - City or Tow Montserrat Dutton-Daughter or other tra 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) Burial 2 X Cremation 3 Baltimore, portant: Creamtory In¢ Metro 5/14/08 Donation 5 Other Specify 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licenses 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed g/ Physician/Medical g physician a UNPENDED ^{AME}, perFH, g879 5/23/08 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the attending por use as the 3 Ectopic pregnancy Dav Live birth Fetal death 2 past 12 months? Pregnant at time of Other (Specify) death Unknown Yes 2 ✔ No 9 Unknown a signed by the a 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has performed' page Yes 2 V No Yes 2 Nο 26 Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other-Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 2 1 Yes No After the 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: within 24 hours after death

To the Funeral Director: A
completely filled in by the fu 1 V Natural Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29h. Signature a d title of certifier May 12, 2008 O.C.M.E. me and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a,25,27,28a-f_perfine 8879,05/13/08dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year MORRIS WILLIAM 0903 MARCH 21 8005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL GTY BALTMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth (Month, Day, Year) 02.08.1932 6 Sex 9. Birthplace (State or Foreign Country) **Funeral** 12 M 2□F Days Hours Director 026.26.0423 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at VI St. John: ST. John 1 ☐ Yes 2 🗷 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 1315 00831 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Engineer Aerospace 12 should be filed who hand Mental Hygien is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Humphrey Morris Margaret Lucile Stanley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Leone N. Morris/Wife P.O. Box 1315, St. John, VI 00831 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 03.24.08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee \$ P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GLIOBLASTOMA MOSTIFORME disease or condition resulting in death) Fon M 71705 /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SUBDURAL 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HEMATOMA STRAKE 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ISCHEMIC 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death
17. Natural
2 Deach 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 02/15/2008 Unknown 1 ☐ Yes 2**X** No Subject fell out of bed. Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 600 N. Wolfe St. Baltimore, MD 4 Homicide Hospital To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) PUTIGEN, MD D0066766 MARCH 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Poriger NORTH WOLFF ST

Registrar DHMH 17 Rev 1/2001 32. Registrar's

BALTIMORE

Maryland 2121 Baltimore,

A

:25

Physician /Medical Examiner

this

P.O. Box 68760.

Vital Records, MARGARET

MASASCHI, Division or requires that the death certificate be executed To the Hospital or Attending Physician: After within 24 hours a To the Funeral I

	Mrs. Nancy Spicer,	/Niece	13110 Pe	endleton Ct.	Reisterstow	n, Md. 21	1136
	20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of or other place)	Date 20	. Location - City o	r Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Themoval from State	rkwood Cer		/20/08 Ba	ltimore.	Maryland
	21. Signature of Funeral Service Licer				Ruck Towson		
	mulant	A Playest		York Road	Towson, Mar		
	23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the dea	th. Do not enter the	mode of dying, such as ca	ardiac or respiratory arrest		Approximate
	Immediate Cause (Final	one cause on each line.	watero 4ss				Interval Between Onset and Death
	disease or condition resulting in death)	a. Due to (or as a consec	nson's	Desea	5e		years
		Due to (or as a consec	quence oi);				J
-	Sequentially list conditions, if any, legaling to immediate	b. — Due to for as a consec					
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Xa	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):				
<u>~</u>							
탏		⊾d					
nysician/Medical	IF FEMALE:	23c. If yes, outcome pf pregn.	ancy				
lar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 □Ectop	ic pregnancy (specify)		23d. Date of de Month	elivery Day Year
ysi	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9□Unknown	Jean 5 One	(Specify)			
7	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyi	ng cause given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
5			,		1 ☐ Yes		robably 4 □Unknown
ompleted by							· –
2					— 24a. Was an autopsy	prior to	utopsy findings available completion of cause of
5					performed 1∐ Yes 2)		s 2 No
מ	25. Was case referred to medical examiner?	119-1			Death (Check only one)		
2	1 ☐ Yes 2 X No		ER/Outpatient 3□	DOA Other: 42 Nursi	ing Home 5 ☐ Residenc	e 6 □Other (Spe	ecify)
=	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred	
eruncanon	2 ☐ Accident investigation		M	1 ☐ Yes 2 ☐ No			
	3 ☐ Suicide 6 ☐ Could not be determined	 28e. Place of injury - At he building, etc. (Specif 	ome, farm, street, fac fy)	ctory, office	28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
<u> </u>						,	
Z Z	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	owledge, death occur	red at the time, date and p	place, and due to the caus	e(s) and manner a	s stated.
Med	one)	and manner stated.		mon, in my opinion, doain	occurred at the time, date	and place, and du	e to trie cause(s)
≥	29b. Signature and title of certifie		1	29c. License number	29d.	Date signed (Mon	th, Day, Year)
	melh	e V Jy V	H	DS 614) 1	May 1	4m 7008

State Registrar

2300 DULANEY VALLEY ROAD

TIMONIUM

MD

21093

30. Name and address of person who completed cause of death (Irem 23a) (Type, Print)

32. Registrar's Signature

ERNESTINE WRIGHT, M.D.

5

31. Date filed (Month, Day, Year)

_			1- State Amend Items 23a, Pt I, II, 25, 27, 28a-f per me, 887	Mental Hy 9,05/13	giene /08dhb Reg. No. 2	10 15007
	Physic		1. Decedent's Name (First, Middle, Last) Carmella A. Marchesi	2. Date of De Month APRIL		3. Time of Death 98 12:40 AM
	/Medi Examiı		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of	
			GREATER BALTIMORE MEDICAL CENTER TOWSON		BAL	TIMORE
	Funeral Director		5. Social Security Number 6. Sex 1 Months 2 T F 86 Yrs. 86 Sex 1 Months Days Hours Min.	8. Date of Bir (Month, Da May 21	rth ay, Year) 9	Birthplace (State or Foreign Country) Maryland
	and w]	Usual Residence of Decedent 10a. State 10b. County 10c. Cify, Town or Location			10d. Inside City Limits
	Maryli f sho ied at	5				1 ☐ Yes 2 ☐ No
	the race race race race race race race rac	rec	MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	λ
	h with	Funeral Director	11630 Glen Arm Road #229 21057		USA	,
	ems ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (St. 17 February 19 Februa	pecify Yes or No)- 14. Race -	American Indian, White, etc.
ح 36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ② No If Yes, Give Year or Dates:	o riiodii, etc.,	Specify:	white
2-0-2	72 ho 'natur dical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kind of Busin	
75 121	vithin ane. than "	mp	Elementary/Şecondary (0-12) College (1-4or 5+)	ung	Baltimor	
R. C	filed v Hygie ther t	ပ္သိ	12 Teacher 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name	ne (First Middle	Public S	CHOOLS
<u>a</u>	ld be lental ked o ic eve	To Be	Joseph Speranzella Mary Ter		, maiden damame)	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru		er, City or Town, Sta	ate, Zip Code)
\(\sigma\)≥	and 2 ealth n 27 i		Cecilia E. Russo / dtr. 644 Towne Center Drive	; Joppa	MD 21085	
H &	ges 1 t of H if iter or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Date	20c. Location - Cit	y or Town, State
ARC H Baltimor	t. Partmen		4 Donation 5 XOther (Specify) entombment Parkwood Cemetery 5/1/	08	Parkville	·
A Bal	Depa Impo any Ir		21. Signature of Funeral Serfice Licensee 22. Name and Address of Facility	1		ork Road
\geq	THE REAL PROPERTY.		23a. Part1. Enter the disease, or complicities that caused the death. Do not enter the mode of dying, such as cardiac			, MD 21204 Approximate
	Physician		Immediate Cause (Final	1	0.6	Interval Between
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	_	V Key	JA HOW
	Examiner		Someonally list conditions by CEREBRO VASCULAR A	CCIDE	PROVED BY MEDICAL	3 EAGUES
MS	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of):	CANAIN AS	PROVED	20.540
2	xecut and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	ERVITA		36/man/135
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9	· - ·	edical	0.			
e. ♠ Box	eath certi attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date o	f delivery
ће О. Е	at the dea by the att	sici	in the past 12 months? 1		Month	Day Year
t CM.	that the ed by detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did t	nhacco use contribu	ite to the cause of death?
f記を Line A cords, P.O. Bo	luires thai n signed b	d by	LASCULAR DEMENTIA	1 🗆		☐ Probably 4 ☐ Unknown
£ 00	aw requir s been si s should t	olete	CRAND MAC SCHOOLS	24a. Was	an 24b. Wei	re autopsy findings available
$\# \mathcal{Z} \mathcal{J}_{p}$ Division or Vital Records,	Attending Physician: The law requires that the death certi rdeath. r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Completed	Atrial Fibrillation, Ischemic Cardiomyopathy	auto	psy prio prmed? dea	r to completion of cause of
/ita	ician; The certificate ector, pag	Be (25. Was case referred to medical examiner?			
o	Physical direction	<u>۲</u>			dence 6 Other	Specify)
ou	ding h. h. After funer	tion	Month, Day Year) Injury Work?		how injury occurred le fall.	
VİSİ	Atten r deat ector: by the	fica	Accident investigation Suicide G Could not be determined Could not be determined Could not be building, etc. (Specify) Could not be building, etc. (Specify	28f. Location (3	Street and Number of	or Rural Route Number.
Ö	tal or rs afte ral Dir	Certification:	Unknown	City or Too	vn, State) M	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical	29a. Certifier (Check only one) **Text	and due to the rred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	fonth, Day, Year)
			KAMAN HOOP A CAN 112. 151228		41281	2008
			39 Name and address of person who completed cause of death (item 3a) (Tylio Print) KAMANA O GOP AC AC MIN FROM IN THE ROLL IN COMPANY OF THE	#JAA,	159 BAL	TIMORE
.0	Sta	te	31. Date filed (Month, Pay Year) 2008 Registrar's Signature	- luctor I.	MD	212-8
	Registr	33.4	WAY I 3 TONO PROPERTY IN THE PARTY OF THE PA			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monthyay **Physician** Day EXERCIS 5:42P Agnes Irene Minton /Medical 4b. City, Town, or Location of Death 4c. County of Death infore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical **Examiner** Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M **2**CXF 215-28-3199 Director Oct. 13, 1930 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f sh t be notified a Director Maryland Baltimore 1 ☐ Yes XX No Mt. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "--- any Injury or other traumant." 1200 Fairfield Avenue 'natural', or items 23a dical Examiner must b 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 21 No Specify: \$ Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Equipment Operator Cup Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearly Benjamin Grafton Viola Margarit ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Minton Husband 1200 Fairfield Avenue, Baltimore, Maryland 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 5/15/2008 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland
Address of Facility
Accordingly 21. Signature / Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC COLON CANCER **Physician** /Medical Due to (or as a consequence of):
HODGKINS LYMPHOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or). be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy jo. Month Day 4□Pregnant at time of death 9□Unknown Year 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 LIVER FAILURE certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: spital: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of Injury 28b. Time of 28c Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this funeral Certification: 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation within 24 hours after occ...
To the Funeral Director, Aft 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MY D 31826 5-13-08 withicum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 RICHARD LINTHICUM M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ROBERT MINICK MAY 1 121. 2008 6:47 AM /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 10/10/1931 Hours 1 M 2 □ F 504-24-8241 SOUTH 76 Director DAKOTA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show be notified at 1 Yes 2 No Director PA. YORK SHREWSBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a o 263 PROSPECT CIRCLE 17361 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black White etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u></u> Specify: WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) MANAGEMENT ANALYST SOCIAL SECURITY other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT MINICK HAZEL OLSON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUNICE MINICK(WIFE) 263 PROSPECT CIRCLE SHREWSBURY, PA. 17361. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 05/11/08 BALTO CITY, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
HENRY W. JENK
16924 YORK RE JENKINS & SONS CO. Signature of Funeral Service Licensee d YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PANCREATIC ADENOCARCINOMA /Medical Due to (or as a consequence of): Examine RECURRENT BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed g physician and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: use If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy φ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page performed? res 2 X No certificate Division or Vital Physician: director, Be 25. Was case referred to medical 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 XInpatient 2 ER/Outpatient 3 DOA P After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 XNatural 2 ☐ Accident (Month, Day Year) Injury death. 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check or 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D 35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 761 INDA FREDA BARR. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAY 1 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item: State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Rosemary Miller /Medical May 8. 2008 12:59 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Timonium If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 TF Director 213-30-8592 Aug. 16, 1932 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at Baltimore 1 ☐ Yes 2 ☐ No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road Funeral 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Buyer Newspaper Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerard A. Miller Laura J. Reinhardt 19a. Informant's Name/Relationship (Type. Print)
Carlene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17763 Piedmont Road Stewartstown, PA 17363 Garlen Russell- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 5/14/2008 Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ship of or heart fails to stonly one cause on each line. Atherosclerote Cardiovarcular Diseas Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2☑LNo Other:

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 14 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

Division or Vital Records, P.O. Box 68760,

2300 DULANEY VALLEY ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MAHMOOD, M.D.

MAY 1 5 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Dav Month Year /Medical 2008 9:00p Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Port Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 214-38-7157 Director 66 26 41 MD Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Exert instructors be notified at 10d. Inside City Limit Baltimore Director MD NA 1X Yes 2 □ N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 U.S.A. 811 North Port Street Funeral Pages 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 □Yes 2 □XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene, 12th grade Technician Westinghouse na is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Virgil Dixon Sr. Elizabeth Pinnick traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 21213 1312 Kenhill Ave, Baltimore, Md Edward Gibson-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 5/14/08 Baltimore, Metro 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 00 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arn1 **Physician** /Medical Due to (or as a consequence of): **Examiner** 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine to (or as a consequence of): burial-tran ۲, death certificate be exec Due to (or as a consequence of): Box 68760. physician Physician/Medical as attending for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ cate has been signated by page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 25. Was case referred to medical examiner? 1 TYes 1 ☐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home Certification: To 1 ☐ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death After 28b. Time of 28d. Describe how injury occurred Injury at Work? 1: Natural 5 Pending investigation 2 Accident 1 ☐ Yes in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only the To the within 7 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

15

MAY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Mary C. Phillips 5-11-2008 9:01a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 10529 Bird River Rd. Middle River Balto. Co. 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ F Months 45 Director 220-74-0029 9-23-1962 Md. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a, State 10c. City. Town or Location 10d. Inside City Limits ?? is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examination or office at Director 1 ☐ Yes 2 ☐ No Md. Balto Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10903 Philadelphia Rd. Funeral 21162 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Completed by If Yes, Give Specify: White 3 Widowed 4 Divorced Specify: Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Balto. City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald L. Phillips Dorothy Ewing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 is any injury or other trau once. Wayne B. Curley Husband 10903 Philadelphia Rd. White Marsh, Md. 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 5-13-2008 Balto.Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Yes 2 page this certificate 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one aminer? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) \(\to \) 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 28d. Describe how biury occurr. or Attending 1 Natural 5 ☐ Pending investigation death. 1 □Yes 2X No 2 Accident **UNKNOWN**M within 24 hours after death

To the Funeral Director:
completely filled in by the 3 X Suicide 4 ☐ Homicide 6 Could not be At home, farm, street, factory, office (Specify) 28f. Location (Street and Number of Rural Route Number, City of Town, State) / 0529 8 m Rues Ru determined Middle RIver, MB 21220 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

1 5 2008

DHMH 17 Rev 1/2001

D

CT Luthonville, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a per dr., g879,05/14/08dhb

Star Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month UILL 108 /Medical na 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 Morley NIA Street If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ X Months Days 7-20-9016 8 Yrs. Director Ma land Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1X Yes 2 □ No Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Stree Morles 21 Completed by Funeral 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1, ☐ Never Married 2 ☐ Married 1 □Yes 2 ZNo Specify. Specify: 3 Widowed 4 □ Divorced "natural". permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, In a Invitoria 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MRmi Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be phroni ဥ ver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Sti Dauto morles 2122 md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Cathedral Com 5-16-08 4 Donation, 5 Dother (Specify) , md. New 21. Signature of Funeral Service License 22. Name and Address of Facility 270 Pass Ba 23a. Part 1. Ent., the isease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Lung Cancer **Physician** 2 - Mo /Medical Due to (or as a c sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 L Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) the 9 Unknown 9 Unknow ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 DANo has funeral director, page 2: autopsy certificate 2 200 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \(\sum \) Nursing Home မ this 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural nours after death.

neral Director: #
y filled in by the fi 2 Accident 1 ☐ Yes 2 🗌 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f (Check 29b. Signature an 29c. License number 29d. Date signed (Mopth, Day, 2001

State Registrar 30. Name and

Martin

31. Date filed (Mg

P.O. Box 68760.

Division of Vital Records,

,22 S. Greene St.

Bathwore.

MD

addless of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Edeima

5 2008

			1 State	partment of Health and Nertificate of Death		2000	15001
	5 11		Registrar 1. Decedent's Name (First, Middle, Last)	erillicate of Death	Re 2. Date of Death	g. No. 4 U U U	3. Time of Death
	Physici		Lewis Franklin Reinhardt		Month	Day Year	A4
1	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 14,	2008 4c. County of Deat	1:40 A.W
			Long View Nursing Home	Manchester		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign untry)
	Director		216-22-4206 XXM 2□ F 81 Yrs. Usual Residence of Decedent	Thomas Buyo Floure	Dec. 29,		ryland
	land ow		10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
	Mary -f sho fied a	ţō	Maryland Baltimore Owings	Milla			1 □Yes 2XXNo
	r 28a	irec	10e. Street and Number	10f. Zip Code		g. Citizen of What Co	
	th wit	Funeral Director	2910 Kenmar Avenue	21117		nited Stat E America	es
	r dea	ne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, White	
36	s afte	by Fu	1 Never Married 2 Married 1 Xes 2 No	1 ☐ Yes 2 No Specify:	r risari, story	Specify: Wh	
21215-0036	hour tural	ed b		edent's Usual Occupation	1	6b. Kind of Business/	
715	in 72 in "ng Mexik	Completed	(Specify only highest grade completed) (Gir Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	king	Baltimore	
212	d with giene er tha	E O		Cable Splicer		& Electric	·
9	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M.	,	
yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Me: Real Examiner must be notified at	P L	Oscar Monroe Reinhardt		Pearl Si		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Merical Examiner must be notified at			ling Address (Street and Number or Rui			
e,	ges 1 and 2 it of Health a if item 27 is or other tra		Lewis Ebert Reinhardt (Son) 1552	B Mt. Olivet Road,		stown, PA	
nor	ages ent of t: If it y or o		Madana 2 Defendation 3 Directional from State		7 16,	_	,
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21 Signature Fundal envised icenses 2	rove Cemetery 200 22. Name and Address of Facility			e, Maryland
ã	Per Dep Per Suny			Eckhardt Funeral Ch 1605 Reisterstown	napel, P.	A.	MD 21117
			23a. Part f. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause of sach line.				Approximate Interval Between
	Physician	n i	Immediate Cause (Final disease or condition	1.0			Onset and Death
	/Medical Examiner		resulting in death) Nue to (or as a consequence of):	1 1 1 1			1000
		<u>.</u>	Sequentially list conditions, bb.	Heart fall	ise		1 mis
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	V			
, C	execu in and ial-tra	Еха	that initiated events c				
8760,	certificate be executed ding physician and se as the burial-transit	dical	d				
Ö	ertifica ing ph	Med	IF FEMALE:				
Box		ian/	23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1	□Ectopic pregnancy		23d. Date of deli	
O	The law requires that the death the has been signed by the atter age 2 should be detached for unage 2.	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		Month	Day Year
σ.	that the by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords,	quires than signed I	d by			1 □ Yes	2 ⊡ No 3□Pro	bably 4 Unknown
ပ္ပ	aw requir s been si s should	Completed			24a. Was an	24h. Were au	topsy findings available
r	The lay	mo	_ar		autopsy performe	prior to c ed? death?	ompletion of cause of
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Deat	1 Yes 2 Land 1		2□ No
o -	Physiclan: r this certificanal director,	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residen	ce 6 ☐Other (Spec	ify)
	ding Phys h. After this funeral dir	ü.	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	Work?	28d. Describe how	injury occurred	
UIVISION	Attending r death. ector: Afte by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s	M 1 Yes 2 No	00(1		
≧	after death after death Director: d in by the	ertification:	4 Homicide determined building, etc. (Specify)	rieet, ractory, onice	City or Town,	et and Number or Ru State)	rai Houte Number,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cau	ise(s) and manner as	stated.
	he Ho in 24 I he Fu pletel	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	with Voit	Σ	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month	, Day, Year)
)	/		Jun 101 1 malin 141)	D2544	3	5/15/24	co f
	5		30. Name all address of person who completed cause of death (Item 23a) (Type Them WM Iddle for 3337 Victory	Street Man	1 - 4-	MNO	1102
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	SHEET THAT	ines ter	1-10 2	y i to diameter
	Registra	-	MAY 1 5 2008 Devel &				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / State of Maryland / Registrar	Certificate of Death	ר	Reg. No. 200	8 5895
	Physicia		1. Decedent's Name (First, Middle, Last) Yvette Alea Robinson		2. Date of D Month May 1		3. Time of Death 11:25P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 834 N. Bond Street	4b. City, Town, or Location Baltim		4c. County of Dea	th /A
	uneral irector		5. Social Security Number 220-04-8410 6. Sex 1 M 2 XF 7. Age (In yrs. last to 3.8)	oirthday) If Under 1 Year If Under 1 Year Months Days Hours	Min. 8. Date of E (Month, Feb.	9. Bir Day, Year) 9. Bir 20, 1970 Ma	rthplace (State or Foreign buntry) aryland
Maryland	-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County N / A 10c. City, To	wn or Location Baltimore	2		10d. Inside City Limits X Wes 2 □ No
h with the	23a or 28a at be notil	Funeral Director	10e. Street and Number 834 N. Bond Street	10f. Zip Code 21 20 5	5	10g. Citizen of What Co	ountry?
-0036 hours after death with the Maryland	tural", or items 23a or 28a-f show al Exeminer must be notified at	ρ	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑ ☑	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 □Yes 2 【XNo Specif		No- 14. Race - Ame Black, White Specify: B	te, etc.
d 21215-0 filed within 72 hov Hydiene	nan "natura Medical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during mo- life. DO NOT use retired)		16b. Kind of Business	·
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af	ked other the	Be	12th Grade 17. Father's Name (First, Middle, Last) Sylvester Joseph McGraw, Sr		ther's Name (First, Mido		Care Pharm. son
Marylan nd 2 should be	Ta E	7		9b. Mailing Address (Street and Nurr. 34 N. Bond St.			
Imore, Pages 1 a	ant; If item 2: ury or other			of Disposition (Name of tery, crematory or other place) Zion Cemetery		20c. Location - City of Lansdowne	e, MD
Balt permit.	Important: l any Injury c		21. Signature of Funeral Service Licensee	22. Name and Address of Fact 4210 Belair			
	sician edical		resulting in death)	INOMA OF TH			Approximate Interval Between Onset and Death
	ıminer	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
68760, tificate be executed	g physician and stransit transit	al Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence				
	attending for use a	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat			23d. Date of de Month	alivery Day Year
IS, P.O	s been signed by the should be detached	by Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Par		id tobacco use contribute t	to the cause of death?
I Records, P.O. Box The law requires that the death cer	e has been a ige 2 should	Completed		7	24a. W	as an 24b. Were a prior to death?	autopsy findings available o completion of cause of
V ital sician: ⊺	certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	Othori	ace of Death (Check on	ly one)	s 2□No
DIVISION OF I or Attending Phys	: After this funeral di	tion: To	1 Inpatient 2 ER/	Outpatient 3 □ DOA □ 4 □ D. Time of	28d. Describ	esidence 6 Other (Sp be how injury occurred	ecify)
DIVISI	To the Funeral Director: After this certifical completely filled in by the funeral director, t	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location City or	n (Street and Number or F Town, State)	Rural Route Number,
e Hospil	e Funera	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowled to the best of				
To th	To th	Me	29b. Signature and title of certifier M. M. M. M.	29c. License numbe	034	29d. Date signed (Mor	1, 2008
5	1		30. Name and address of person who completed cause of death (Item 23 MATTHIAS HOLDHOFF, M.),	a) (Type Print)		LTIMORE, M	021231
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sporte			

DHMH 17 Rev 1/2001

08-03542								
Juanita	D	Reddy						

anita D Reddy		1- For State	Maryland / D	epartmen <i>Certificate</i>			Menta	al Hy		Reg. No	2	008	1589	
Physicia	an/	1. Decedent's Name (First, Middle,Last)				· · · · · ·		2	Date of Dea	ath Day			me of Death 518 hrs	
edical Exami	ner	Juanita Denise Red	y yet and number\		I dh	o. City, Town, or L	ocation of	Death	May 9, 20		4c. County of		3161115	
		Franklin Square Hospital	let and number /		1	Rosedale				1	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lat						_	8. Date of Birth (MM/DD/YYYY)			9. Birthplace (State or Foreign Maryland Country)		
		216-04-6405 1_M	2XF	38	Yrs. Months Days Hours Min.				Oct.1	varyrand				
any		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or I	ocatio	n						10d.	Inside City Limits	
the Maryland a or 28a-f show		Maryland Baltimore Essex									1 [Yes 2 X No		
		10e. Street and Number	L			10f. Zip Code	-				itizen of Wha	t Country?		
		5 Maple Drive Apt.		21220					USA					
th with	Funeral	1 XNever Married 2 Married	er in U.S. 13	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica				Rican, etc.) White, etc.						
ter dez ", or i		3 Widowed 4 Divorced If Ye		No	1 ,	Yes 2 X No	specify:				Specify:	lack		
ours af atural xamin	d by	15. Decedent's Education (Specify only hi	ates: ghest grade complet	ted) 16a. Dec		s Usual Occupation				16b	. Kind of Busi	ness/Indus	try	
136 hin 72 hours a e. than "natura edical Examin	olete	Elementary/Secondary (0-12) 11th grade	College (1-4 or 5+)	Home	-	_	30 140 1 0	30 roure	•• /	P	rivate	Home:		
5-000 led withi Hygiene. other th	Completed	17. Father's Name (First, Middle, Last)				la:	B.Mother's	Name (First Middle	, Maide	en Surname)			
21215-0036 Muld be filed within 72 hours at Mental Hygiene. marked other than "natural c event, the <u>Medical Examin</u>	Be	Louis Reddy												
21 Should and Me is may	4	19a. Informant's Name/Relationship (Type, Sylvia Reddy/ Mothe	Print)	410 410	ailing 4 T	Address (Street Urf Run	C11C	leer R		Ste	OWNO, IMEN	State, Zip 211	Code)	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		20a. Method of Disposition		20b. Place of D	isposit	ion (Name of cem	etery,		Date	20	c. Location - 0			
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 F	temoval from State	crematory Greenmo	or othe	er place) : Cemeter	y !	5/16	/08	Ва	altimor	e, Ma	aryland	
altin nit. Pa artmen sortan ury or		4 Donation 5 Other Specify: 21. Signature of Funeral Server I ce see						hat	man_Ha	arr	is Fune	ral E	łome	
Per Per E	1	Lever Mire	1			ame and Address								
Physician /Medical		23a. Part I. Enter the disease, or complicati failure. List only one cause on each li	ne.				uch as ca	rdiac or	respiratory a	rrest, s	shock, or hear	t Ap	etween Onset and	
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
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	miner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a conseque	ence of):								- 10		
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50, te be executed ysician and burial - transit	cal E	d.	4ENDED	••										
50, te be e lysicial	fedical	IF FEMALE: AMENDED 23a, 27, per/MF, g880 6/25/08 TT 23c. If yes, outcome of pregnancy 23d. Date of delive										lelivery		
certificate be ending physicia	sician/M	23b. Was decedent pregnant in the past 12 months?	Live birth	2	Feta	al death 3	Ectopic	pregnar	ісу		Month	Day	Year	
Section of pregnancy Section of pregnancy														
the c	/ Phy	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the ur	nderlying cause gi	ven in Par	t I.	23e. Did	tobac	co use contrib	ute to the	cause of death?	
ires that I signed b	d by												4 Unknown	
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of Vital I ing Physician: After this certifi uneral director,	: To	1 ✓ Yes 2 No	28a. Date of Injury (Month, Day, Year)			0 20.	•				injury occurre		_	
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Div Hospital or 24 hours after Funeral Di	O	4 Homicide determined (Specify) 29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a second of the cause of the cau										4		
	Medical	(Check only one) 2 ✓ Medical Examiner: On	the basis of examina	nowledge, death ation and/or inve	occurr estigati	ed at the time, dat on, in my opinion,	e and pla death occ	ce, and curred at	due to the ca the time, da	iuse(s) te and	and manner a place, and du	as stated. ie to the ca	use(s)	
To the within To the comple	Med	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (A												
		Tolans A				O.C.N	O.C.M.E. May 9, 20					08		
		3 ame and address of person who comp			_	32				_			-1177	
	1 7/3	,	nt Medical Exam			n Street, Balti	more, N	1D 212	201					
S Regis	tate	31. Date filed (Month, Day, Year) MAY 15 2008	32 Registrar's	Signature	004	le)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIPM/19a, per INF. 08/9, 5/28/08, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** MAY EDWARD J. SLABA 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner APUNIX WALTIMORE WARHINGTON MEDICAL CEN BURNIE 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days if Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1**X**M 2□ F 218 05 6363 91 0.5 15 1916 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No by Funeral Director Anne Arundel Pasadena MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21122 173 Roland Rd. U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1942 1 XYes 2 □ No If Yes, Give 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 1945 White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mail Carrier U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Michael Slaba Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sister 173 Carroll Rd. Pasadena, MD 21122 important: if item 2: any injury or other to Bronetta Czarski -daughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem 5/15/08 | Dundalk, MD 22. Name and Address of Facility GJ Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 23a. Part1. Exfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GAM GRENE **Physician** disease or condition resulting in death) /Medical Examiner SCIEDOTIC CAPTOLASCULAR DISEASC Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 27. Mann of Death funeral Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No s after dec. 2 ☐ Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 45 30 date and address of person who completed cause of death (Item 23a) (Type, Print) Gear bornie MS 20161 Acc. MY 31. Date filed (Month, Day, Registrar's Signatur Year) State MAY 1 5 2008 Registrar

ORIGINAL

Q В

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Taylor Reece Stevens Certificate of Death 1- For State Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Time of Death Physician/ May 11, 2008 REECE TAYLOR STEVENS 0626 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 1236 Hilldale Road Rosedale 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) MD Months Days Hours 2/13/1985 Director 219 15 3214 23 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD BALTIMORE ROSEDALE 1 Yes 2 X No show Director 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number 21237 USA 1243 HILLDALE ROAD Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces Yes 2 X No WHITE f Yes, Give Yeer Specify: Widowed Divorced Yes 2 X No specify: <u>۾</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 BUILDING Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than yr other traumatic event, the Medica ELECTRICIAN 12 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) F. STEVENS PATRICIA L. MARKEL ROBERT Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT F. STEVENS/FATHER 1243 HILLDALE ROAD BALTIMORE, MD 21237 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
METRO CREMATORY 1 Burial 2 X Cremation 3 Removal from State 5/15/08 BALTIMORE, MD portant: ury or oth Donation 5 Other Specify: 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service I censee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Fentanyl intoxication and mixed drug (Cocaine, Oxycodone, Methadone Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): USE Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last f, perME, g879 Physician/Medical 5/23/08 TT X UNPENDED X 4MENDED #23a 2 perMEg8/9 physician the burial -The law requires that the death certificate be Box 68760, IF FEMALE: 23d. Date of delivery If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Day Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. <u>გ</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate h Yes 2 No 1 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be examiner? Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 1 Yes 2 XNo Pending Fnd 5/11/2008 Funeral Director: tely filled in by the unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 11, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 32. Registrar's Signature 31. Date filed (Mg 15 2008 State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

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	Funeral Director		5. Social Security N		Sex 7. Ag	ge (In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year	ISON If Under 24 Hrs. Hours Min.	8. Date of B	irth Day, Yea	r) Co	nplace (Statuntry)	te or Foreign
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	th the	Director	10e. Street and Nu	mber		l			p Code			10g. C	Citizen of What Co	-	
	ath wi	<u>[a</u>	7928 Be	lridge Ro						21236				USA	
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. other than "natural", or Items 23a or 28a-f show ant, the Medical Examination pust be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	ried 2□ Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S		Was Dece If Yes, spe 1 ☐ Yes		lispanic Origin? (S) an, Mexican, Puerti Specify:	pecify Yes or N Pican, etc.)	lo-	14. Race - Ame Black, White Specify:		
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	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau			□ Cre <i>m</i> ation 3 l	Removal from State	20b. P	lace of Dispo emetery, crei Δir Me	matory or	other place	dns.5-15-	Date 2008		el Air,M		
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Box 687	Attending Physician: The law requires that the death certificete be executed reath. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome	2 Fetal	death 3	Ectopic		у			23d. Date of del	ivery Day	Year
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O.	law requires that the dias been signed by the 2 should be detached	by Pl	Part II. Other signi	ficant conditions	contributing to death b	out not resu	alting in the u	nderlying	cause giv	en in Part I.			o use contribute to		
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Division of Vital Records.	he law e has l	Completed									per	opsy formed?	death?	completion	gs available of cause of
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Div	al or A s after i Directed in by	Certification: To	4 Homicide	determine	28e. Place of In building, et	tc. (Specify	()	cet, lactor	y, onice		City or To	own, Sta	aria Number of Hi ate)	nai noute n	uniber,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one)		Physician: To the best aminer: On the basis and manner st	of examinal									se(s)
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 $13^{\text{Day}}~2008^{\text{Year}}$ Month MAY **Physician** NAT SCHEIN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner BALTIMORE RANDALLSTOWN SEASON'S HOSPICE @ NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 X M 2 □ F 09/24/1913 579-26-8716 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 28a-f show Funeral Director MD BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or ; any hlury or other traumatic event, Ite Madical Examiner in set be or 3440 ASSOCIATED WAY, #410 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. If Yes, Give Year or Dates: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEN'S CLOTHING OWNER / OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCHEIN DORA HARRY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3440 ASSOCIATED WAY, #410, OWINGS MILLS, MD 21117 ROSE SCHEIN / WIFE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05/14/2008 TIFERETH ISRAEL BALTIMORE, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RENAL FAILURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dehydration Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 X No 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 1, Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

1:45P M

Birthplace (State or Foreign Country)

USA

WHITE

MESSNICK

Day

29d. Date signed (Month, Day, Year)

May 13th 2008

Year

ÄÚSTRIA

10d. Inside City Limits

1 □Yes 2 No

ours after death.

neral Director: Af
filled in by the fur within 24 hours a

To the Funeral C

completely filled

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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State

Registrar

PHYSICIAN

Svite 203

32. Segistrar's Signatur

DO

301) Marne and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 05-09-2008 **Physician** Alice F. Smith 3:15p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 9 - 1 4 - 1 9 4 8 Harbor Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 T F N.C. 59 Director 213-52-2819 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No must be notified Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21217 23a 1620 Mckean Ave. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian or Items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16h. Kind of Business/Industry Private than College (1-4or 5+) Elementary/Secondary (0-12) Personnel Security other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F is marked of 2 Nathaniel H. Smith Lavenia Battle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. 905 Dartmouth Glen Way Baltimore, MD 21212 Dana O. Crockett/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5-17-08 Woodlawn, MD Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) 08 W. North Ave. Baltimore, MD 21201 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, reading to minieulate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hinknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 🗌 Yes certificate 2∏ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2€ ER/Outpatient 3 DOA ၉ 1 | Inpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending investigation il Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific and address of person who cor

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5902 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician TAYLOR LESLIE 4:55 A TURNER MAR 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☑ M 2 🗆 F 50 **Director** Jan 27, 1958 Maryland 218-72-6073 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show MD Howard Director Columbia 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 6334 Cedar Lane 21044 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or Items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed by white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Edward Taylor Dorothy Jean Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Lerner/cousin 14031 Cantor Court Queen Anne, MD 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature i zuneral Service Licen. ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK **Physician** SEPTIC disease or condition resulting in death) /Medical Emon 71703 Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if ny cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last O'BY MEDICAL EXAMINER Examiner death certificate be executed CERTIFICATION APPROVI attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Quadriplegia, Metastatic Cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has e 2 page this certificate 1□ Yes 2 XNo after death.

Director: After this certification 25. Was case referred to medical examiner?

1 X Yes 2 40 Be 26. Place of Death Check onl one) Hospital: 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Matural 5 Pending investigation Subject passenger in a vehicle collided with a vehicle
28t. Location (Street and Number or Rural Route Number, City or Town, State) October, 1979 Unknown 2 Accident 1 ☐ Yes 2 No filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 ☐ Homicide Elkridge, MD Roadway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Hospital

> M. Brad Drummond 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier



MAY 13 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c, License number

D0062560

29d. Date signed (Month, Day, Year) MAR 15, 2008

Columbia Maryland 2694

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9:20P M FRANCIS XAVIER TUNNEY May 9. 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Stella Maris Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Days | Hours | Min. | April 22, 1919 | Mary I and 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **X**XM 2□ F 219-05-9478 89 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland | Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1XXNever Married 2 Married 1 ☐ Yes XIX No Specify. Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Office Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Thomas Tunney Agnes Monaghan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue K Walker P₀A 8008 Rider Avenue Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery May 13,2008 Pikesville, Maryland Signature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. CASE233 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Samo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Grknown 24a. Was an autopsy performed?
1□ Yes 2☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes No 6 Sther (Secry 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

Physician /Medical Examiner Examine

Department of Health a important: If item 27 is any injury or other trainonce.

Pages 1

Physician

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

Be

death with the Maryland

Baltimore, Maryland 21215-0036

as use has been signed by te 2 should be detact

Physician/Medical Completed by Be P Certification:

Medical

Box 68760. P.O. or Vital Records, or Attending Division within 24 hours after deam.

To the Funeral Director; Af

State Registrar

EDDIE NAKHUDA, M.D. 31. Date filed (Month, Day, Year)

6 Could not be determined

certifier

3 ☐ Suicide

29a. Certifiei

29b. Signature a

4 Homicide

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 512.08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD TIMONIUM, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

. Registrar's Signature MAY 1 5 2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and M 25,27 per me, g879 05/113/08/119/eath	lental Hy		8 15904
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	3	3. Time of Death
	Physici		Leo Stanley Wolski	Month	Day Ye	ar D
	/Medi			05-		
1	Examir	ier			4c. County of E	,
		38	Franklin Square Hospital Center Rosedale 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I funder 24 Hrs.			imore
ŀ	Funeral		Months Days Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	01/04/	1921 Ma	aryland
	and		10a. State 10b. County 10c. City, Town or Location			40d Inside City Limits
	sho sd at	৯				10d. Inside City Limits
	he N 18a-f	Sc	Maryland N/A Baltimore			1 DXYes 2 No
	vith t	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	<u>a</u>	417 S. Ellwood Avenue 21224	1	United Sta	ates
	r de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - A	merican Indian,
ဖွ	afte or it		1 Anever Married 2 Married 1 Tyes 2 M No Specific	r near, etc.)		
ö	ours iral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: V	MIT CE
5	72 h inatu dical	ete	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	na	16b. Kind of Busine	ss/Industry
2	within ene. than "l	횯	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ing		
21215-0036	filed wi Hygier Ither th	Completed	10 Sexton		Catholic	Church
pu	be filk	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden Surname)	
<u>a</u>	uld b Aent rked rked tic e	To	Frank Wolski Frances 2	wara		
Maryland	should and Men s marke umatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura		er, City or Town, State	e. Zin Code)
Ξ	nd 2 alth a 27 is					
ē,	s 1 a f Hea item othe		20a. Method of Disposition 20b. Place of Disposition (Name of	ate	re, Mary La 20c. Location - City	
2	Pages nent of l int: If its		17 Julia - Doromadori o Diremoval nom otate	5/2008	·	,
Baltimore,	# E 문 를		4 Donation 5 Other (Specify) Saint Stanislaus Cemetery	<u>I</u>	Baltimore,	Maryland
Ba	permi Depa Impo any la		21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funer	al Home	es P.A.	
		-	401 S. Chester Stree	et Balti	imore. Mar	yland 21231
			23a. Part 1. Fi ter the disease, or complications the death. Do not enter the mode of dying, such as cardiac or shorts or heart failure. List only one cause on each line.	r respiratory arr	rest,	Approximate
B	Physician		Immediate Cause (Final disease or condition Tethicillia resistant Stant	hilling	APLIC AL	Onset and Death
6	/Medical		resulting in death) Due to (or as a consequence of):	11910C0	rea 5 an	1 602
В	Examiner			,	n MITHUS	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it in y that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): CERTIFICATION APPROVE	~ F	ALDIC.	
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	BY MEDICALE	XAMILLE	
Ć,	exec n an iaf-tr	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	e be sicia bur	cal				
89	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit		0.			
×	leath certific attending p	Physician/Med	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome pf pregnancy			=0000
Box	eath atten for u	ian	in the past 12 months?		23d. Date of o	felivery Day Year
o.	at the de by the a tached	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)		World	Day real
Ω.	that the	F				
Ś	res tl	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
5	w require been sign	fed	Acute Renal Failure	1 □ Y	es 2□No 3□	Probably 4 □Unknown
Records,	law r as be 2 sh	Completed by	Bilateral Premmonia	24a. Was a	an 24b. Were	autopsy findings available
ř	sician: The law certificate has b irector, page 2 s	E	4	autops perfori	sy prior t med? death	o completion of cause of ?
Vita			25. Was case referred to medical 26. Place of Death	1□ Yes		es 2 No
	Physician: r this certifica ral director, p	o Be	examiner? Hospital:			
ō	r this	⊢	This input on the contract of		ence 6 □Other (S	pecify)
DIVISION OF	Attending Phys r death. ector: After this by the funeral dir	<u></u>	1 □ Xatural 5 □ Pending (Month, Day Year) Injury Work?	od. Describe no	ow injury occurred	
S	te eal	Ca	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be			
<u> </u>	or Atten after deatl Director: in by the	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (St City or Town	treet and Number or n, State)	Rural Route Number,
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	Hosp 4 ho Fune ely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manager of the death occurred and manager of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the time, date and place, a continuous content of the death occurred at the death	nd due to the ca	ause(s) and manner	as stated.
	the lin 2 the li	eq	and manner stated.	at the time, d		ue to the cause(s)
	2 ¥ € 2	2	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mo	nth, Day, Year)
	1		D-38752	1	05-02	2-2008
	(2)	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	2 -	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALIKA CASELLIM. 709. BASTERN BLUD	, M-1	11 - 212	21.
	Stat		31. Date filed (Month, Day, Year) MAY 1 3 2008 MAY 1 3 2008			
	Registra		MAY 1 3 2008 Januar Dr. April			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ Decedent's Name (First, Middle, Last)
CARL EDWIN 2. Date of Death 3. Time of Death WHITESEL **Physician** Month MAYDAY) EXMOR 7:00F /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 12-21-1928 Social Security Number 216-24-8798 7. Age (In yrs. last birthday) 79 Yrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F PENNSYLVANIA Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD BALTIMORE RASPEBURG Director 1 ☐ Yes X☐ No 10e. Street and Number 5606 DAYBREAK TERRACE 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify 9 Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) SCARFER BETHLEHAM STEEL 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARL EDWIN WHITESEL CARRIE (VAN SCYOC) ၉ 19a. Informant's Name/Relationship (Type. Print)
EDNA MAE WHITESEL/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 Is r any Injury or other traur 5606 DAYBREAK TERRACE BALTO., MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 5-13-08 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 211 CHESACO AVE ROSEDALE, MD 21237 21. Signature of Funeral Service Licensee T211 CHESACO AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) 2 □ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 certificate 2 **X** No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification; Hospital or Attending To the Hospius ... within 24 hours after death.

To the Funeral Director; Aft 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

5

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KOUROSH MASTALI M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 64509

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year DAVID CLARK WOOD, SR. 810 5 2008 /Medical 2 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN Square HospiTHL Center Rosedal 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) **Funeral** 9. Birthplace (State or Foreign M 2□F Days 226-50-4812 Director VIRGINIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Hean 27 is marked other than "natural", or items 23a or 28a-f show arry fulvor or other traumatic event, the Medical Examiner must be notified at 28a-f show Director 1 ☐ Yes 2 No MD BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 168 BENNETT ROAD by Funeral 21221 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itel 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) HEALTH CARE & Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL FINANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WOOD MAMIE ROBERTS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nood DIXIE J. WOOD/ WIFE 168 BENNETT ROAD, ESSEX, MARYLAND 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 5/14/08 BALTIMORE, MARYLAND 21. Signature of F service Licensee L'ILLY & ddresse ILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SPICATION Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Congestive

Due to (of as a consequence of): HearT FaiLure attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed certificate 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 5 2008

ERIC

Ritter



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KLin Square

RES 0000

DR

Balto

5-12-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Maryland	d / Depa	artment of H	ealth and N Death		jiene leg. No.	008	15907
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physicia							Month April 2	Day 200		11:00 A M
	/Medic Examin		Virginia May Bla 4a. Facility Name (If not institution, give	CKDUYN street and number)		,	Location of Death	1236777	4c. Cour	nty of Death	
1			Allegany County	Nursing Center	- A friedhodou o	Cumber 1	and If Under 24 Hrs.	8. Date of Birt		egany g. Birth	place (State or Foreign
	Funeral	1	5. Social Security Number 6. Set	IM OFF	Vea	Months Days	Hours Min.	8. Date of Birtl (Month, Day	, Year) 1918 –	MD	intry)
	Director	-	217-14-4001 Usual Residence of Decedent	- N - 2X - 89	2			May 28,	1910		10d. Inside City Limits
	/land	H	10a. State 10b. County	10c. City	y, Town or Lo	ocation					1 ☐ Yes 🛠 🖟 No
	Man a-f st	cto	MD Allega	ny Lii	ttle O	rleans			10g. Citizen	of Minet Col	
	or 28	Director	10e. Street and Number			10f. Zip Code			iog. Citizeri		muy:
	23a unit b	la l	11410 Price Road,	N.E.	0 40	21766 Was Decedent of H	lienanic Origin? (S	necify Yes or No	14. i	USA_ Race - Amer	ican Indian,
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 257No	5. 113.	If Yes, specify Cuba	an, Mexican, Puert	Rican, etc.)	E	Black, White,	, etc.
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "fedical Evanting must be notified at	<u>م</u>	1 ☐ Never Married 2 ☐ Married 3 ☐ With the control of the contro	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No XX	Specify:			Whi	
15-0	"natur	Completed	15. Decedent's Edi (Specify only highest grad		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	king	160. King 0	of Business/II	ndustry
2121	withir ene. than		Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker				Home	
	filed Hygi sther		17. Father's Name (First, Middle, Last)		1101110	11001102	18. Mother's Nar	ne (First, Middle,	Maiden Suri	name)	
lan	ld be lental ked c	To Be	Ellis L. Sulliva	in				E. Barne			
Maryland	shou and N s mar		19a. Informant's Name/Relationship (7		19b. Mail	ling Address (Street					
Ž,	and 2 salth a 27 iv		Ann Miller/Daught	er	1141	O Price I	Rd., N.E.	Little Date	Orlea	ns MI	21766 Town, State
ore	of He		20a. Method of Disposition	Removal from State		oosition (Name of ematory or other pla	ce)				
Ĕ	Pag tment tant: I		X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			V Christia 22. Name and Addre		4/2008		mas, I	PA
Baltimore,	permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licen Richard Grov	re per DVR		Frove Fundament		l West			
	40200		CO. Deat 4 Fator the discoss of comm	plications that caused the dea	th. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	22,00	Approximate Interval Between
			shock, or heart failure. List only	one cause on each line.							Onset and Death 5 Vears
-4	Physician /Medical		disease or condition resulting in death)	a. <u>Coronary</u> Due to (or as a consec	ALCELS quence of):	Disease					
	Examiner			h .							
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	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):						
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8760,	physic the b	Physician/Medical		d							
9 X	leath certifica attending ph	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancy	-			230	d. Date of de	
Вох	eath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		3 ☐ Ectopic pregnar 5 ☐ Other <i>(specify)</i>				Month	Day Year
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S, P.	res that the de signed by the a i be detached i	þ	Part II. Other significant conditions		sulting in the	underlying cause g	iven in Part I.		Yes 2		Probably 4 Unknown
ord	v requir been s should	Completed	Diabetes Melli				71	24a. Wa		24h Were a	utopsy findings available
ec	law has b e 2 sh	nple						- aut	opsy formed?	prior to death?	completion of cause of
aF	r: The ficate r, pag	ပိ					26 Place of D	1 L Yes eath (Check only	~~	1 □ Ye	\$ 2 140
Vit	sician: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpat	tient 3 DOA O		Home 5 ☐ Re		☐Other (Sp	ecify)
of	ding Phys h. After this funeral dir	15.	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time	e of 28c. Inj		28d. Describe			
on	nding th. r: Afte	atio	Natural 5 Pending 2 Accident investigation	n		M 1	□Yes 2□No				
Division of Vital Records,	or Atte fter dea lirecto n by th	Certification: To	3 Suicide 6 Could not be determined		home, farm,	street, factory, office	9	28f. Location City or T	(Street and own, State)	Number or F	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying P	hysician: To the best of my k miner: On the basis of exami	nowledge, de	eath occurred at the	time, date and pla y opinion, death oc	ace, and due to the curred at the time	ne cause(s) a e, date and p	and manner place, and di	as stated. ue to the cause(s)
	the Hi in 24 the Ft	Medical	one)	and manner stated.			nse number				nth, Day, Year)
	Vith Vith	Σ	29b. Signature and title of certifier	01)				MAY	, 10 TH	
			"Keleustano	1. Haven	M (33280		MAJ		000
	-		30. Name and address of person who	- 500	Momo	ial Avenu	10 Cumber	land MD	21502		
		tate	Robustiano Barre 31. Date filed (Month, Day, Year)	32 Refistrar's Sig	inature	I AVEIL					
	Pagis		MAY 1.5	2008 Marie	15	Sparker.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** CARL F. BUTLER, SR. 09 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□F 68 234-62-3436 Director Sept.11,1939 Keyser, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 X Yes 2 □ No Director WV Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 and 2 should be filed within 72 hours after death with ' Health and Mental Hygiene. 9m 27 is marked other than "natural", or items 23a or 2 De L ms 23a must b 94 "C" Street 26726 Funeral Race - American Indian, Black, White, etc. "natural" or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 No If Yes, Give Year or Dates Unknown 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) 10 Sheet Metal Worker Sheet Metal Fabrication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer Butler ဥ Mildred Biser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 94 "C" Street Health Frances R. Butler/ Wife Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth May 13 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Potomac Memorial Gardens 4 Donation 5 Dother (Specify) 2008 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Smith Funeral Home 85 S. Main Street Keyser, WV 26726 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. udden Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner anglane Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that builtiesd as ort injury Due to (or as a nsequence of): Examiner attending physician and for use as the burial-transit certificate be executed Del1 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 ☐ Unknown been signed by t should be detach م Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No 24a. Was an has autopsy performed? Yes 2 No octonsion 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Donpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Division 1 Watural or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours a To the Funeral I To the Hospital

State Registrar

D. CKISHOLM 31. Date filed (Month, Day,

29b. Signature and title of certifier

924 Seton Drive, Cumberland, MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D34362

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03385 State of Maryland / Department of Health and Mental Hygiene Armelvis Booker Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day May 3, 2008 1257 hrs Physician/ Medical Examiner c. County of Death Town, or Location of Death 4b. City, 4a. Facility Name (if not institution, give street and number **Baltimore County** Essex Franklin Square Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year Age (In yrs. last birthday) 5. Social Security Number Foreign **Funeral** Days Hours Months Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 23a or 28a-notified at Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Armed Forces? Never Married 2 Yes 2 No specify: Yes If Yes, Give Year Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examiner. Widowed Divorced 16b. Kind of Business ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 18 Moyner's Name (First, Midg 17. Father's Name (First, Middle, Last) 19h Mailing Address 2 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Baltimore, Removal from State 2 Cremation 3 Burial Other Specify Donation 5 f Funeral Service Lice f. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval 23a. Part I. Enter the disease, or complications **Physician** failure. List only one cause on each line Death /Medical Epidermoid tumor of brain Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last RT and transit Physician/Medical X UNPENDED AMENDED 23a, 27, perME, g881, 7/2/08 TT signed by the attending physician be detached for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 0. 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy death? performed' has 1 🗸 ✔ Yes 2 certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be Nursing Home 5 Residence 6 Other: examiner? Hospital: DOA Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 No 1 X Natural Pending Director: In by the f 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 4, 2008 O.C.M.E. me 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. strar's Signature 31. Date filed (Mon Rey Year) 2008 State Registrar OCME

DHMH 17 Rev 1/2001 OCME 2006

			Please Type or Print in Black Indelible In		•	•	
			State of Maryland / Department of Certificate o		Mental Hy	000	
	Discolation		Decedent's Name (First, Middle, Last)	, Douth	2. Date of De	eath Day Year	3. Time of Death
	Physici /Medic	al	Andrew Betz Blake		April	28 200	
	Examin	er		n, or Location of Dea nnapolis	atn	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) If Under 1 Yea 578–14–5294 81 Yrs. Months Day		1. (Month, D	rth 9. Bi	thplace (State or Foreign ountry)
	ס		Usual Residence of Decedent		March	7, 1927 Wa	shington, DC
	Maryla -f shov	호	Maryland 10b. County 10c. City, Town or Location 10c. City,	Annapolis	5		10d. Inside City Limits 1XXes 2 □ No
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, I'te Madical Evan her must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 7101 Bay Front Drive, Apt. 413 2	21403		10g. Citizen of What C	•
	ms 23a	Jeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent o		Specify Yes or No	U.S.A	
36	orite,	by Fu	1 □ Never Married 2 2 Married 1 2 MYes 2 □ No □ □ □ If Yes, Give 1 Q 1 1 □ Yes 2 MS N		rto Rican, etc.)	Black, Whi	te, etc. White
2-0036	2 hour natural ical Ex	ted k	15 Decedent's Education 16a Decedent's Usual Occ	cupation	and sing a	16b. Kind of Business	/Industry
121	within / ene. than "i	mple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ (Give kind of work dor life. DO NOT use reti		Jiking	Drug Sto	ore
nd 2	0 0 0	Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Na		e, Maiden Surname)	
Maryland 2121	should be filed and Mental Hygi s marked other umatic event, I	으	William Joseph Blake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stre		la Betz	City on Town Chate	Zin Code)
, Ma	and 2 s ealth an n 27 is I ner trau		Helena B. Blake/wife 7101 Bay Fron				
Ψ.	permit. Yages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p		Date	20c. Location - City or	
altin	permit. Pa Departme Important any Injury once.		4 □ Donation 5 □ Other (Specify) Rock Creek Cernete 21. Signature of Funeral Servine Licensee 22. Name and Ado		2/2008 John M T	Washington Taylor Fune	
nă —				of Glouce	ester St	. Annapoli	s, MD 21401
	hysician		Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. Immediate Cause (Final	lying, such as cardi	1	7027	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a	10 (10)	e (a)	ncer	7(5,
	-xammer	ē	Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying				
	n and lal-transit	Examiner	that initiated events c.				
<u>ا</u> و	burl le	- 1	Due to (or as a consequence of):				
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ROX	attenc d for us	ician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of de Month	elivery Day Year
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ecords, P.O	After this certificate has been signed by the funeral director, page 2 should be detached	d by	Factor. Other significant continuous continuously to death out not resulting in the underlying cause (given in Part i.			robably 4 Unknown
မ န	as bee	Completed			24a. Was	an 24b. Were a	utopsy findings available completion of cause of
VITAI H	ificate P	e Con	25. Was case referred to medical		perfo 1 □ Yes	ormed? death? 2 No 1 Ye	s 2 No
OT VITA	his cert	To Be	examiner?	Mh ===	eath (Check only only only only only only only only	one) idence 6 ☐Other (Spe	ecify)
ם סבס	After t	tion:	27. Manuer of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. In Month, Day, Year) 28c. In Natural 1	njuryat /ork? □Yes 2 □No	28d. Describe	how injury occurred	
VISION	rector:	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			(Street and Number or R wn, State)	ural Route Number,
ָה ק	ours aff		29a. Certifier 1 Certifying Physicann: To the cest of my knowledge, death occurred at the	e time, date and pla			us stated
NOISINIA	within 24 hours after death, To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical 5 miner: On Le basis of examination and/or investigation, in mone) manner stated.	y opinion, death occ	curred at the time,	, date and place, and du	e to the cause(s)
		V	29b. Signature and title of derittier 29c. Lice	tinse number 1978		29d. Date signed (Mon	
	S)C	X	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ue rd	A312	Bowle	M320716
	Sta Registra		31. Date filed (Month, Day, Year) APR 3 0 ZUU0 APR 3 0 ZUU0			-	
	negistra		HEN O U COULD JOHNE OF FORE	_			

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Mary Frances Boarman 29, 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 615 Tower Bank Road Severna Park Anne Arundel if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) District 5. Social Serity Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗶 F 61 219-72-9274 Director Jan. 27,1947 Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner nest be notified at Anne Arundel Director MD Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hyglene. Important: If flem 27 is marked other than "natural", or items 23a ~ ~ once. 615 Tower Bank Road 21146 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Settlement Officer Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Vandegrift Mary Margaret Connell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Boarman/husband 615 Tower Bank Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Ppd 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ym hema disease or condition resulting in death) /Medical Due to (or as a con a quence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter United Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) pital or Attending Physician: The law requires that the death certificate be executed ours after death.
eral Director: After this certificate has been signed by the attending physician and filled in by the functoral director, page 2 should be detached for use as the burial-transit filled in by the functoral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Medical Certification: To

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TTEM/5 per FH (280) 6/9/08 WS State of Maryland? Department of Health and Mental Hygiene

3. Time of Death

5:45 A

of Columbia

10d. Inside City Limits

Approximate Interval Between Onset and Death

Y/a-

Year

Day

1 ☐ Yes 2 No

and manner stated 29b. Signature and title of certifier

APR 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orfire MO 22 31. Date filed (Month, Day, egistrar's Signatur Year)

State Registrar

within 24 hours a

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Ma		rtment of Health and tificate of Death	Mental Hygie	6000 13912
Physician /Medical	Decedent's Name (First, Middle, Last) WILLIAM GEORGE B	ARRON		2. Date of Death Month	Day Year 3. Time of Death 10:10 P M
Examiner	4a. Facility Name (If not institution, give street and number) 15766 Easthaven Court 5. Social Security Number 6. Sex 7. Age) (In yrs. last birthday)	4b. City, Town, or Location of Dea Bowie If Under 1 Year If Under 24 Hr	ith	4c. County of Death Prince George 's
Funeral Director	122-05-0766 1 X M 2 ☐ F Usual Residence of Decedent	86 Yrs.	Months Days Hours Mir	8. Date of Birth (Month, Day, Ye) Dec. 23,1	921 Canada
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show singly journ other traumatic event, its Medical Exertial or must be notified at once. To Be Completed by Funeral Director	10a. State 10b. County	10c. City, Town or Loc Bowie	ation 10f. Zip Code	10-	10d. Inside City Limits ¼ Yes 2 ☐ No Citizen of What Country?
ath with 23a or number of	15766 Easthaven Court	1	20716	U	SA
urs after death v	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: V	0	las Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ed within 72 ho ygiene. her then "natura it, it e Medical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5	+) (Give k	ent's Usual Occupation ind of work done during most of w O NOT use retired)	orking	o. Kind of Business/Industry
Mental Hygic Mental Hygic Mental Hygic Mic event, II	17. Father's Name (First, Middle, Last)	Restat		mme (First, Middle, Mar th G. Held	ood Industry den Sumame)
id 2 shoul ith and Mg 7 is mark traumati	19a Informant's Name/Relationship (Type, Print) Mary Barron/ Wife		Address (Street and Number or F Easthaven Court	Rural Route Number, C	
Pages 1 arent of Health of Health	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispos cemetery, crem Metropo	ition (Name of atory or other place)	Date 200	2. Location - City or Town, State
Dermit. P Departm Importar eny Inju	21. Signature of Funeral Service Licensee	22.	Name and Address of Facility $ m Rc$ $ m 5000~Annapolis~R$	bert E. Ev	ans Funeral Home
Physician /Medical Examiner		е.	r the mode of dying, such as cardii	ac or respiratory arrest	Approximate Interval Between Onset and Death
icate be executed physicien and it the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Line, underthing Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a current of the condition of the condition of the current	a consequence of): a consequence of):			
the death certification of the attending of the attending of ached for use as a check for use a check for		2 ☐ Fetal death 3 ☐ I	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
wrequires that s been signed it s thould be deti	Part II. Other significant conditions contributing to death bu	it not resulting in the un	derlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Munknown
vical neconorsistem. The law requirester, pege 2 should be Completed			7777-677	24a. Was an autopsy performed	
To the Hospitel or Attending Physician: The Within 24 hours elter death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatie		Other	Home 5 X Residence 28d. Describe how	e 6 ☐ Other (Specify) injury occurred
Itel or Attending Programmers eller death. Tel Director: After fled in by the funera	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injubuliding, etc.	ry · At home, farm, stre . (Specify)	et, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
To the Hospitel or Attendi within 24 hours elter death. To the Funeral Director: P completely illed in by the it.	29a. Certifier 11 ertifying Physician: To the best of check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or invi	occurred at the time, date and placestigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
Something A	29b. Signature and title of certifier	\bigcap	29c. License number MD# 035807		Date signed (Month, Day, Year) RTL 29, 2008
COC.	30. Name and address, pers in who completed cause of de ELIZABETH LINDENBERGER, M.D.			W, WASHING	TON,DC 20422/688
State Registrar	31. Date filed (Month, Day, Year) APR 3 0 2008	r's Signature	and a		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrary MFND#23e-29aperMD5-2-08, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>008</u> **Physician** 20:34 PM Charles Michael Brown 25 April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours Yrs 44 Director March 9. 1964 Washington, DC 579-84-1878 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10a State 10b. County ₩ Yes 2 No Washington, D. C. District of Columbia Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n United States 20019 4701 Alabama Avenue, S.E. by Funeral 14. Race - American Indian, items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ★ Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ginee. Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur 12th. Caterer Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Mack John Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1247 Howison Place, S.W. Wash., D.C. 20024 Ann Brown (Sister) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 € Burial 2 □ Cremation 3 🖪 Removal from State May 2,'08 Washington, D. C. Glenwood Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 3831 Georgia Avenue, N.W. 21. Signature of Funeral Service Licensee Latney's Funeral Home Washington, D. C. 20011 # MD 278 23a. Part1. Enter the disease, or complications that caused the deut. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed | 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No 24a. Was an autopsy performed? Yes 2X No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes ※ No 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, 29c. Lipense number Day, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carroll Ave, #205; Takoma Park, MD 20912 0 NASREEN 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 1 2008

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 26, 2008 **Physician** 6:45 PM April Alden Beecher Bestul /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days **Funeral** Months Hours 1 № M 2 🗆 F Sept. 01, 1921 South Dakota 86 Director 048-22-3217 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Rockville Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9400 Overlea Drive 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 X Widowed 4 ☐ Divorced Year or Dates: Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 5+ Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adele Bakke Helmer Julius Bestul 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janis Bestul Ossmann / Daughter | 28 Lothrop Road, Acton, MA 01720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/2/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sery Simple Tribute 20852 1040 Rockville Pike, Rockville, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or leart failure. List Immediate Ca. (Final disease or condition **Physician** Aspivation resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronau if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ot): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 ttend ng physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□ Yes 2 No 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 1 🗆 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Medical Certification: (Month, Ďay Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined

the Hospital or Attending Physician: To the Hospital of within 24 hours at To the Funeral D

> State Registrar

31. Date filed (Month, Day, Year) MAY 0 1 2008

29b. Signature and title of certifier

29a, Certifier

(Check only one)

9901 Medical Center Drive, Rockville, MD 20850 Poopak Ghassemi Bakhtiari, M.D. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

i 🗹 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Franklin	Braxton.	Jr.
Hallkiill	Diaxion,	01.

		I- For State Registrar	Certific	cate of Death		Reg. I	vo. 201	18 1591
Physicia	ın/	Decedent's Name (First, Middle,Last)				Date of Death Month Da	ay Year	3. Time of Death
ledical Examii		Franklin Braxton,				May 3, 2008		1120 hrs
		4a. Facility Name (if not institution, give stre		4b. City, Town, or Cheverly	Location of Death		4c. County of Death Prince George	
		Prince George's Hospital Cent	7. Age (In yrs. last b		r If Under 24Hrs.	8 Date of Birth(N	MM/DD/YYYY) 9. Bir	
Funeral Director		5. Social Security Number 6. Sex		Months Days		1	Foreig	www.Washington.
Director		579-82-8228 1 x M	² F 40	Yrs.		July 3,	1967	DC
. è	H	Usual Residence of Decedent 10a, State 10b, County	10c. City, Tow	n or Location				10d. Inside City Limits
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Maryland 28a-f show d at once,	휧	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
e Mar or 28	Director		NE	20019			United St	ates
ith th		4231 Clay Street,	Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-		ican Indian, Black,
eath v	Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 No	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	White, etc.	
fler de		3 Widowed 4 Divorced If Ye	s, Give Year	1 Yes 2 X No	specify:		Specify: B1	ack
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)			18.Mother's Name			
2121 ould be f Mental marked ic event	Be	Franklin Braxton, 19a. Informant's Name/Relationship (Type,		19b. Mailing Address (Stree		Louise V		e Zin Code)
MD 21215-0036 4 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once.	٩	Annie Braxton - Mo		4231 Clay St				
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ti. Partmen		4 Donation 5 Other Specify: Signature of Funeral S rvice e ee	Ft.	Lincoln Ceme 22. Name and Addres				
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Sox 687 leath certifing e attending for use as t	sian	past 12 months?	Live birth Pregnant at time of death		ccopic pregna	aricy	Worter	Day
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician	1 Yes 2 No 9 Unknown	Unknown	o ottras (opecas)				
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tal Rection: The certificate	č	25. Was case referred to medical		26.Plac	e of Death (Check	only one)		
Vital Rec ysician: The I his certificate I director, page	o B	examiner? 1 ✓ Yes 2 No	ital: 1 Inpatient 2 🗸 EF	VOutpatient 3 DOA	Other Nursi	ng Home 5 R	esidence 6 Oth	er:
n of Vital Records, P.O. ding Physician: The law requires that th. After this certificate has been signed by funeral director, page 2 should be detae	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)		ury at Work?	28d. Describe ho	w injury occurred	
ision Attendia er death. ector: A	ţį	1 Natural 5 Pending 2 Accident Investigation		Nd 10:30 am	Yes 2 X No		ngested alco	
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be executed reached. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 X Suicide 6 Could not be	28e. Place of Injury - At home	e, farm, street, factory, office	building, etc.			Rural Route Number, City
Divi	Sert	4 Homicide determined	(Specify) residence				st. NE, Wash	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, the basis of examination and/	death occurred at the time, o	date and place, and	d due to the cause	(s) and manner as st	ated. the cause(s)
To the Hos within 24 h To the Fur	Medical	an	the basis of examination and/ d manner stated.		nse number	a. the time, date al	29d. Date signed (A	
	Σ	29b. Signature and title of certifier			.M.E.		May 4, 2008	ionar, vay, rear
		Matrice Uro	nica-Molla	h is				
7		30. Name and address of person who com Patricia Aronica-Pollak MD.	pleted cause of death (Item 23 Assistant Medical Ex		Street, Baltimo	re, MD 21201		
7.0	2010	31. Date filed (Month, Day, Year)	32. Registrar's Signature		,			
S Regis			and K for	ule				

ORIGINAL

State of Manyland / Department of Health and Mental Hygiene Cartificate of Death Must Ce Sylventer Black Jr. State of Manyland / Department of Health and Mental Hygiene Cartificate of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Jr. State of Death Must Ce Sylventer Black Sr. State of Death Must C	8-03435	Please Type or Print in Black Indelible Ink. Ensure All Copi	
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ABULTICE Sylvester Black Jr. May 5, 2008 181 A learny and content methods of the street of north methods of the street of the street of north methods of the street of the str		Registrar	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07^{Day} 2008 Year **Physician** 9:40 P May Adele Marise Donnelly /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Washington Homewood Retirement Center Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 💢 F 97Yrs. 214-46-5159 MD October 25, 1910 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Weddall Examiner must be notified at 1¥∏Yes 2 ☐ No Director Hancock MD Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21750 5246 Western Pike by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental h 1 and 2 should b Health and Ment Mary Louise Paine ပ Rinehart Cohill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 Department of Health a Important: If item 27 is any Injury or other tra Ralph Hanks Donnelly, III/Grandson 1311 Seaton Circle Falls Church, VA 22046 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/12/2008 Smithsburg, MD 4 Donation 5 DOther (Specify) Smithsburg Crematory 22. Name and Address of Facility wure Funeral Service Licensee 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of unich line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pass disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-trans attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ZNo 9 ☐ Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Hypertensiol 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Physician: ours after death.

Neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of person who completed cause of death (Itan

DHMH 17 Rev 1/2001

State Registrar (24 FP)
Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

31. Date filed (Mc Yy, Year 8 2008

Assistant Medical Examiner

			For State	State of Ma			rtment of H tificate of I			giene Reg. No	63 M M M	1501	1
			Registrar 1. Decedent's Name (First, Middle	e, Last)		001	- Imouto or i	- Journ	2. Date of De	ath		3. Time of Death	1
	Physici /Medic	al	David John Daco	•					April	20			
5	Examin	er	4a. Facility Name (If not institution 1520 Governors				•	r Location of Death onville	n		c. County of Deatl Anne Aru		
	Funeral		5. Social Security Number		e (In yrs. last birt	hday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birl	th	a Rint	Inlace (State or Foreign	7
k	Director		213-56-4717	1∰M 2□F	53	Yrs.	Months Days	Hours Min.	12/31/	195	4 Wash	ington, D.C.	,
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits	
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	vith the	Director	10e. Street and Number	Drides Dood			10f. Zip Code 2103	_	I	_	itizen of What Co ted Stat	-	
	leath v ns 23a must	Funeral	1520 Governors	_	Ever in U.S.	13. V		J lispanic Origin? (S an, Mexican, Puerl			14. Race - Amer	rican Indian,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1	Yes, specify Cuba	an, Mexican, Puèri <i>Sp</i> ec <i>ify:</i>	to Rican, etc.)		Black, White Specify: Wh	e, etc. ite	
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nd	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle,						me (First, Middle,	, Maide	n Surname)		
yla	d Men narke	မ	Michael Paul Da		10h	Mailin	a Address (Street	Miriam and Number or Ri		or City	or Town State 7	In Code)	_
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ore,	es 1 a of Hei		20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation	-			sition (Name of patory or other place		Date		Location - City or		
<u>ă</u>	t. Pag tment tant: I		4 □ Donation 5 □ Other (S	(pecify)	Lakemon	t Me	norial Gard	dens 04/:	30/2008	Dav	idsonvil	le, Marylaı	ıd
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	Physician		Immediate Cause (Final disease or condition	_a.	BV	rai	u tom	or Iglia	oblastou	Ma		Onset and Death 2VVS 2M	2
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	of):		10				,	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence o	of):							_
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68760,	icate be executed physician and s the burial-transit	al E		Due to (or as	a consequence o	01):							
		ledical		d						[_
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P.O. E	he dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	time of death	5□	Other (specify) _			:	World	Day Tear	
	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditi	ons contributing to death b	ut not resulting ir	n the ur	derlying cause giv	ven in Part I.	23e. Did 1	tobacco	use contribute to	the cause of death?	
Records,	w require been sig should b								10	Yes :	2 % -No 3□ Pr	obably 4 Unknown	1
Seco	ne law r has be ge 2 sh	Completed							24a. Was	psy	prior to	itopsy findings available completion of cause of)
	ate pag	e Col	25. Was case referred to medica	ıl T				26 Place of Do	1□ Yes	ormed?	death? No 1 ☐ Yes	2 No	_
Z	Physician: r this certificanal director,	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 ☐ ER/Ou	itpatien	t 3 DOA Oth				6 □Other (Spe	cify)	_
Division or Vital	ing Pt		27. Manner of Death 1 Natural 5 ☐ Pendir			Time of njury	28c. Inju Wo		28d. Describe	how inj	ury occurred		
isic	Attending r death. ector: After by the fune	licati	2 Accident investi 3 Suicide 6 Could	not be 28e. Place of inj	ury - At home, fa	ırm, str	M 1 □ eet, factory, office	Yes 2 No	28f. Location (Street a	and Number or Ri	ural Route Number,	_
2	s after s after al Dire	Certification:	4 ☐ Homicide determ	building, et	c. (Specify)				City or To	wn, Sta	ite)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis of and manner st	f examination an		vestigation, in my	opinion, death occ		, date a	and place, and due	e to the cause(s)	
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			_ FOI	ertificate of Death	ntal Hygiene Reg. No.	2008 15920
1 84	Physici /Medi		1. Decedent's Name (First, Middle, Last) Robert Steven Duda, Sr.	A	Date of Death Month	Near 3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Cheverly If Under 1 Year If Under 24 Hrs. 8.		County of Death Cince Georges 9. Birthplace (State or Foreign
	Funeral Director		183-28-6730 13⊠ M 2 ☐ F 72 Yrs. Usua! Residence of Decedent	Months Days Hours Min.	(Month, Day, Year) ine 2, 193	Country)
	e Maryland a-f show iffled at	ctor	10a. State 10b. County 10c. City, Town or I Maryland St. Marys Califo			10d. Inside City Limits 1
	tth with the Marylar 23a or 28a-f show ust be notified at	al Director	10e. Street and Number 23785 Kingston Creek Road	10f. Zip Code 20619		zen of What Country?
920	after des or items miner m	by Funeral	· · · · · · · · · · · · · · · · · · ·	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici		14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) Territory Manager		nd of Business/Industry
Maryland 2	uld be filed Mental Hygi irked other itic event, <u>ti</u>	To Be C	17. Father's Name (First, Middle, Last) Stephen Duda	18. Mother's Name (Fi		Surname)
	is 1 and 2 should be filed of Health and Mental Hyg Item 27 Is marked othe other traumatic event,	9	Robert S. Duda, Jr./Son 13633	ing Address (Street and Number or Rural Rush Hartsbourne Drive,	Germantow	
Baltimore,	t. Page: rtment o rtant: If I		4 Donation 5 Other (Specify) Metropol	osition (Name of ematory or other place) itan Crematory 4/29/ 22. Name and Address of Facility DeVo	2008 Ale	xandria, Virginia
B B	Department Department Impo			O East Deer Park Dr.	, Gaither	sburg, MD. 20877 Approximate Interval Between
760,	death certificate be executed e attending physician and for use as the burial-transit	I Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): Due to (or as a consequence of): C. Minning Confucitions of the consequence of):	no se to 5597		Onset and Death
9	leath certificate battending physic	Medical	d	p k		
.O. Box	that the death c ed by the attend detached for us	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	w requires that the been signed by th should be detache	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the Motor Vehicle acc) den t	underlying cause given in Part I.		se contribute to the cause of death?
al Reco	The law ate has b page 2 sh	Completed by	Multiple Fracture of the upper ext	remities	24a. Was an autopsy performed? 1☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
or Vit	Phys this ral dir	n: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at 28d	5 ☐ Residence €	y occurred DRIVER FEE
Division or Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After, completely filled in by the funer	Medical Certification:	1	A, M 1 ☐ Yes 2 ☐ No 3 treet, factory, office 28f.	Location (Street and City or Town, State,	WHOSE AND TREE ONUMBER OF BURIAL ROUTE NUMBER, P. C. REFER R. C. N. S. F. MAYS CO. N.D.
	the Hospit in 24 hours the Funera pletely fille	edical C	29a. Certifier (Check anly one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, and	due to the cause(s)	and manner as stated.
	がいると	M	29b. Signature and title of certifier Med m	29c. License number		e signed (Month, Day, Year)
-	-		30. Name and address of person who completed of use of death (Item 23a) (Type	, Print)		

State Registrar

WILLAM 31. Date filed (Month, Day, Year) MAY 0 1 2008

Boyle

col Hospital DR, CARDERLY, DRD. JETST Horpital Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month E1sa Apri1 Britta Sofia Dah1man 2008 12:45 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner #1118 1316 Fenwick Lane Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Sept. 23, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Yrs 216-64-5670 Sept. Director 88 1919 Sweden Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 √Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Fenwick Lane #1118 20910 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Caucasian þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 Homemaker/ Language Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked John Magnusson E1sa Magnusson and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other trau once. Barbaro Dahlman / Daughter 7407 Holley Avenue, Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 5/3/2008 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or con if on resulting in death) **Physician** Chronic obstructive pulmonary disease /Medical Due to (or as a consequence of): Examiner Alzheimer's Dementia 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence offi be executed burlal-transit and Due to (or as a consequence of): physician sthe burlal Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death Month 5 Other (specify) ceen signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has pege 2 s autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident ompletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the P within 2-29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58401 April 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8120 Woodmont Erica W. Hwang, M.D. Ave. #320, Bethesda, MD 20851

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 01

2008

legistrar's Signature

Edwards Runs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	4	State of Maryland	-	rtment of H			giene Reg. No. 🤈 🕦 🎧	00 15000
			Registrar 1. Decedent's Name (First, Middle, Last)	007	imouto or i	J G G G I	2. Date of Dea	ath	3. Time of Death
	Physicia /Medic			wards			May	12, 2008	
	Examin	er	4a. Facility Name (If not institution, give street and number)	;	4b. City, Town, or E1k1	Location of Death		4c. County of	eci1
- 4-			Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt (Month, Da). Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 $\stackrel{7. \text{Age (In yrs. In }}{1 \text{ M}} = 1 \text{ Age (In yrs. In })$	Yrs.	Months Days	Hours Min.	Oct. 12		North Carolina
	0		Usual Residence of Decedent	, Town or Lo	nation				10d. Inside City Limits
	aryla show	<u> </u>			battori				1 □Yes 2 No
	28a-f	ect	Maryland Cecil El	kton	10f. Zip Code		T	10g. Citizen of Wh	at Country?
	3a or	Funeral Director	1138 Leeds Road			21921		United	States
-	ms 2	ner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 14. Race - Black,	American Indian, White, etc.
9	should be illed within 72 hours after death with the maryland ind Mental Hygiene. Independent Hygiene and there is narked other than "natural", or items 23a or 28a-f show umatic event, the Meulcal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □ Yes 2 🛣 No	Specify:	,		White
0000-	atural cal Ex	ted b	15. Decedent's Education	16a. Deced	lent's Usual Occup	ation during most of work	ing	16b. Kind of Busi	iness/Industry
ה ה	thin /	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	`life. L	DO NOT use retired	1)	n ig	Twomanan	etation
7	lygien lygien rt, the		12 17. Father's Name (First, Middle, Last)	Tr	uck Driv		e (First Middle	Transpor	
מנים	ntai H ed otl	Be	Paul Edwards				la Reev		<i>'</i>
2	should nd Me mark imatic	유	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			er, City or Town, S	tate, Zip Code)
<u> </u>	alth ar 27 is 27 is er trat		Margaret Edwards/Wife	1138	Leeds R	oad, Elkt	on, MD	21921	
	of He of He in other		20a. Method of Disposition 20b. P 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 2	lace of Dispo emetery, crei	sition (Name of matory or other plac		Date	20c. Location - C	ity or Town, State
Ĕ	ment ment tant: I		4 □ Donation 5 □ Other (Specify) R.A.		& Co., Inc		4, 2008	West Chest	ter, PA
Dalitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Itaal Examiner must be notified at once.		21. Signature of Funeral Service Licensee	1 1	03 W. Stock	ss of Facility for Funeral cton St., E	lkton, MD	21921	
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
F	hysician	ľi	Immediate Cause (Final disease or condition	CAVO	Al -	In FA	ch'sN		Oriset and Death
	/Medical Examiner		Due to (or as a consequence of the consequence of t						
		je.	Sequentially list conditions, if any, leading to immediate	uance of):					
d	cūted nd ransit	Examiner	rany, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-					
200/9	ficate be executed physician and ts the burial-transit	EX	resulting in death) Last Due to (or as a consequence of the consequenc	uence of):					
200	ficate physics the b	dical	d						
ROX	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Me	iF FEMALE: 23c. If yes, outcome pf pregna 23b. Was decedent pregnant 1 □Live birth 2 □ Feta		∃Ectopic pregnanc	у		23d. Date	of delivery th Day Year
	he dea the att	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of d 9 □ Unknown	eath 5	Other (specify)				ar Day rous
ς, Γ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contrit	bute to the cause of death?
Sp	equires en sig	ed by	Hyper TENS,ON		1. / /		10	Yes 2 No 3	3 Probably 4 ⊞Unknown
ecora	The law requires that the te has been signed by that page 2 should be detache	Completed	Non Insulin Depends	n f	Diabete.	s Mp/(1)	24a. Was	psv pr	ere autopsy findings available for to completion of cause of
		Соп					1□ Yes	2 No 1	eath? □Yes 2□No
VItal	sician certifi rector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	S Outration	nt 3 DOA Oth	26. Place of Dea			(0
ō	y Physer this eral di	T. To	27. Manner of Death 28a. Date of Injury	28b. Time o	II 3 DOA	4 🗀 Nursing H		idence 6 □Othe how injury occurre	
0	ath. rr: Afte	atior	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2□No			
DIVISION	or Atte fter de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At he building, etc. (Specification of the building) and the building of the buil	ome, farm, st fy)	reet, factory, office			(Street and Numbe own, State)	r or Rural Route Number,
_	spital lours a neral I		29a. Certifier Certifying Physician: To the best of my kno	owledge, deat	th occurred at the t	ime, date and place	, and due to the	cause(s) and mar	nner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and the funeral director, to the funeral director, the funeral director director, the funeral director director directors director directors director directors director directors director directors director directors director directors director directors director directors director director directors director directors director directors director directors director director directors director di	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	ation and/or ir			irred at the time		
	With To t	Ž	29b. Signature and title of certifier		29c. Licen:	se number		29d. Date signed	(Month, Day, Year)
•			1.7/Josel (1)	n 22a) /Turn	1 1)	1318		VVIAY 1	2 2008
	3		30. Name and address of person who completed cause of peath (Iter	3 2 /	eonles.	MYEA ,	News	1K De	19702
d		ate	31. Date filed (Month, Day, Year) 32. Registrar's Sim	ature	2)				
	Regist	rar	11111 20 2000 10000 100						

DHMH 17 Rev 1/2001

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		For State Registrar	Cer	rtificate of E	Death	Re	eg. No. 🥠 🎧	100	1100
Physicia	an	1. Decedent's Name (First, Middle, Last)	by Fetterhoff	:	1	2. Date of Deat Month	h Day	Year	3. Time of Death
/Medic Examin	N. 2	4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or Hagersto			4c. County	of Death	
Funeral Director		· · · · · · · · · · · · · · · · · · ·	ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 19		9. Birthpl Count Penn	lace (State or Forei try) 12.
M ti		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				11	0d. Inside City Limi
a-f she	ctor	Penna. Franklin	Greencas	stle					1 □ Yes 2 💢
3a or 28 it be no	I Dire	10e. Street and Number 4192 Coseytown Rd.		10f. Zip Code 1722	5	1	0g. Citizen of W U.S.A.	/hat Coun	itry?
gene. r than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Married 1 Marri	No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🂢 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		e - Americ k, White, : Whi	etc.
n "natural" Medical Ex	Completed b	3 Widowed 4 Divorced Para or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or street)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired,	ution uring most of working	ng	16b. Kind of Bu		·
er thai	W _O	10	Uph	olsterer			Furnitu		•
ed other	B	17. Father's Name (First, Middle, Last) Albert Fetterhoff			18. Mother's Name Olive Ye	, .	Maiden Surnam	ne)	
r reaun and menta Item 27 is marked other traumatic ev	2	19a. Informant's Name/Relationship (Type. Print) Jane S. Fetterhoff/Wife		ng Address (Street a				State, Zip	Code)
nt: If item 2		20a. Method of Disposition 1	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place Church Cemet		oate /08	20c. Location -	•	
Department of important: If its any injury or of once.		21. Signature of Funeral Service Licensee		2. Name and Addres			d Son Fun		
physician and stransit autorical stransit autorical stransit autorical stransit autorical stransit autorical stransical s	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): A 4 Y S a consequence of):	tery	Disegr	_			
physicians the bu	Physician/Medic		2 Fetal death 3	□Ectopic pregnancy				te of deliv	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con							Day Year
n signed by the attuild be detached for	þ		but not resulting in the ι	underlying cause give	en in Part I.		24		the cause of death
as been s 2 should			but not resulting in the u	underlying cause give		1 Nas 24a. Was autor perfo	rmed?	3 ☐ Pro	the cause of death
is certificate has been s director, page 2 should	Be Completed by	Part II. Other significant conditions contributing to death	tient 2 ⊟ER/Outpatie	ent 3□ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	24a. Was autor performent of Check onlocome 5 Resident	res 2 A No an 24b. ssy rmed? 2 A No ne dence 6 Ott	3 ☐ Prof Were autr prior to co death? 1 ☐ Yes	the cause of death bably 4
death. ctor: After this certificate has been s / the funeral director, page 2 should	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 3 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of in	tient 2 □ ER/Outpatie jury 28b. Time o lnjury njury - At home, farm, st	ent 3 DOA Oth of 28c. Injur Wor M 1	26. Place of Deat er: 4 ☐ Nursing Ho	24a. Was autor period to the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check onl of the Check on th	an 24b. 24b. 24b. 24b. 24b. 24b. 24b. 24b.	3 ☐ Pro Were auto prior to co death? 1 ☐ Yes mer (Speci	the cause of death bably 4
death. ctor: After this certificate has been s / the funeral director, page 2 should	Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of in (Month, D) 28b. Place of in building, 6	tient 2 ER/Outpatie jury ay Year) 28b. Time of Injury njury - At home, farm, stetc. (Specify)	ent 3 DOA Oth of 28c. Injur Wor M 1 treet, factory, office	26. Place of Deat er: 4 ☐ Nursing Ho y at k? Yes 2 ☐ No	24a. Was autop performent of the control of the con	an sy 24b. an 24b. an 24b. an 24b. an 24b. an 24b. an 24b. an 24b. an 24b. an 34b.	3 ☐ Pro Were auto prior to oc death? 1 ☐ Yes mer (Special tred ber or Run anner as	the cause of death bably 4 Unknown opsy findings availampletion of cause 2 No ify) ral Route Number, stated.
death. ctor: After this certificate has been s / the funeral director, page 2 should	Certification: To Be Completed by	Part II. Other significant conditions contributing to death a condition of the condition of	tient 2 ER/Outpatie jury ay Year) 28b. Time of Injury njury - At home, farm, stetc. (Specify) st of my knowledge, dea of examination and/or in	ent 3 DOA Oth of 28c. Injur Wor M 1 treet, factory, office	26. Place of Deater: 4 □ Nursing Hoy at k? Yes 2 □ No	24a. Was autop performent of the control of the con	an say 24b. an 24b.	3 ☐ Pro Were autoprior to codeath? 1 ☐ Yes mer (Special red ber or Run lanner as a and due	the cause of death bably 4 Unknown upsy findings available properties of cause 2 No No Note: A Route Number, stated. to the cause(s)
 After this certificate has been s funeral director, page 2 should	To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Getermined 29a. Certifier (Check only 1 Ch	tient 2 ER/Outpatie jury ay Year) 28b. Time of Injury njury - At home, farm, stetc. (Specify) st of my knowledge, dea of examination and/or instated.	ent 3 DOA Othor 28c. Injur Wor M 1 treet, factory, office ath occurred at the timestigation, in my case 29c. Licens	26. Place of Deater: 4 □ Nursing Hoy at k? Yes 2 □ No me, date and place, opinion, death occur e number	24a. Was autop performent of the control of the con	an say 24b. an 24b.	3 ☐ Pro Were autory rior to condeath? 1 ☐ Yes mer (Special red mer or Ruin manner as and due and (Month)	the cause of death? bably 4 Unknown opsy findings availating availating of cause 2 No ify) ral Route Number, stated. to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 29, 2008 Year **Physician** Betty Lee FELDMAN 1:15 A ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year)
Sept. 11, 1922 Illinois If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕡 F 335-22-2557 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1/☐Yes 2☐No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 'natural", or items 23a 6105 Montrose Road United States permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If them 27 I marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Footwear 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Rosenberg Isadore Ulevitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5656\ Stone\ Lake\ Dr.,\ Dayton,\ OH\ 45429$ 19a. Informant's Name/Relationship (Type. Print) Steven Blumhof, son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State Peoria Hebrew Cemetery 05/02/08 Peoria, IL 4 □ Donation 5 □ Other (Specify) 21. Signature of Funedal Service Licensee Törchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1 End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Two Years disease or condition resulting in death) a End Stage Renal Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 🔀 No signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a. Westerman April 29, 2008 D 52451

Registrar

State

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-eldman, Bett

31. Date filed (Month, Day, Year)

MAY 0 1 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael A. Westerman, M.D., P.O. Box 2316, Kensington, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Cletis Ormond Guthrie /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** August18,1963NorthCarolina **™** 2 □ F Director 241-21-6346 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State X□Yes 2□No Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21218 5511 Elderon Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

★□ Yes 2□ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify Black Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Specialist Micros Company 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen J. Gorham Nelson Guthrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27889 19a. Informant's Name/Relationship (Type. Print) 818 North Respess Street, Washington, North Car. Helen J. Guthrie 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 5-12-08 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michael P. marguello 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 months cancer Physician Luna /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23d Date of delivery If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2:0 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: Hospital: 1. Inpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 14 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident death. after death. the 1 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by t 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled filled CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8,2008

State

DHMH 17 Rev 1/2001

Registrar

Union Memorial Hospital, Md

address of person who completed cause of death (Item 23a) (Type, Print)

Quianzon

			For State Registrar	State of Ma	,		rtment of Ho tificate of D		1ental Hy	giene Reg. No	0000	1 1	(92)	
j.	Physicia		1. Decedent's Name (First, Middle, Las	Jose		G	uevara		2. Date of Do Month April	ath Da	2008 Year	3. Time (of Death A	
	/Medic Examin		46 Chy Tours and continue of Death											
	Funeral Director		5. Social Security Number 6. S 577-60-8886	ex 7.Ag X⊆M 2□F	e (In yrs. last birth	rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D) 03/15/	rth ay, Year 1919	9. Birth Cou Vene	place (State intry) zuela		
	Maryland -f show	tor	Usual Residence of Decedent										City Limits	
	th with the 23a or 28a ist be notif	al Director	10e. Street and Number 4970 Sentinel Dr		10f. Zip Code 20816			10g. Citizen of What Country? Venezuela						
980	Pages 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Heath and Mental Hygiene. and: I fleem 27 is marked other than "natural"; or items 23a or 28a-f show ant: I fleem 27 is marked other than "natural"; or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at	by Funeral	3 Widowed 4 Divorced 178s, Give 151 Tes 2 Divo Specify: Verific Zue 1 all Specify: W							14. Race - Amer Black, White Specify: Whi	, etc.			
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government Venezuela								-			
		To Be Co	17. Father's Name (First, Middle, Last)											
Mar	nd 2 shoulth and 27 is mare rtrauma		19a. Informant's Name/Relationship (Type. Print) Elizabeth Guevara / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4970 Sentinel Drive #405 Bethesda, MD 20816											
Baltimore, I	Pages 1 an nent of Hea ant: If Item 3 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State	20b. Place of I cemetery	Dispos , cren	sition (Name of natory or other place Crematory	9)	Date , 2008	20c. l	Location - City or 1 1s Churc	Town, State		
	permit. Page Department of Important: If any injury or once.		21. Signature of Fiveral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016											
The Section Williams	Physician // Medical Ex physician and physician and physician and the pnial-transit	shock, or heart tailure. List only one cause on each line.											ate etween d Death	
			Sequentially list conditions	Due to (or as Corona:		10 Yea	ırs							
		Examiner	di any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diabetes Mellitus Due to (or as a consequence of):								5 Yea	ırs	
3876	icate be physicia s the bu	dical		_d										
Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Unknown 23d. Date of delivery 23d. Date of delive								very Day	Year		
al Reco		Completed by	Parkinson's Disease Parkinson's Disease 24a. Was an autopsy performed? death? 1 Yes 2 2kNo 1 Yes								death?	ompletion of	s available cause of	
Zit.		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	26. Place of Death (Check only one) Other: 4 Nursing Home 5									
vision or Vital		Certification: T	27. Manner of Death 1 ★ Natural 5 Pending investigatio 3 Sulcide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No										
		Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (M.											a(s)	
		Σ									,			
7			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan M. Weintraub MD 5530 Wisconsin Ave. Chevy Chase, MD 20815											
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 1 200	2. Regist	trar's Signature	40		Januacy	1111 200					

The law requires that the death certificate be executed s certificate has t lirector, page 2 s dire

To the Hospital or Attending Physician: within 24 hours after death.

To the Funneral Director: After this certifica s after death.

I Director: After this of in by the funeral d in 24 hours the Funeral Directory filled in completely

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1, 2008 11:55 AM May Harvey Leon Gentry, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11000 Woodlawn Blvd. Prince George's Largo 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 11XM 217 F North Carolina Yrs Aug 30, 1945 244-62-1605 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No MD Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 11000 Woodlawn Blvd. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1961–65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Courier Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Long Wallace Gentry, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11000 Woodlawn Blvd. Largo, MD 20774 Catherine T. Gentry/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 MacCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 05/02/08 Beltsville, MD 21. Signature of Funeral Service 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 TT MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? diabetes, coronary artery disease, hypertension 1 Tes 2 No 3 Probably 4 Munknown Completed renal failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2√ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28386 Q UN MS MD 5-1-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffery T. Hoeck, M.D. 4175 . Hanson Ct. Suite 203A Bowie, MD 20716 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

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Registrar

2001 Medical Parkway Annapolis, Md 21401

30. Name and address of person who completed chase of death (Item 23a) (Type, Print)

APR 3 0 2008

lacque line

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Anne Heenan April 27, 2008 11:45 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgonery

9. Birthplace (State or Foreign Country) Gaithersburg <u> Ashbury Methodist Village</u> If Under 1 Year | If Und 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthdav) 5. Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F Yrs Feb 17, 1908 Director 100 Canada 577-60-4822 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 301 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊋ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√□No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mas Department of Health, Elementary/Secondary (0-12) College (1-4or 5+) Education and Welfare Clerk Typist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Bristo Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5224 Willow Mill Drive; Marietta, GA 30068
ace of Disposition (Name of Date 20c. Location - City or Town, State Don Heenan / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5-5-2008 Lincoln Crematory: Brentwood, MD 22. Name and Address of Facility
Simple Tribute 21. Signature of Funeral Service Licensee Jus di-1040 Rockville Pike; Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caus d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congester chest **Physician** week /Medical Due to (or s a consequence of): Examiner utensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed and burial-tran Due to (or as a consequence of) attending physician requires that the death certificate be Physician/Medical the as for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☑ No Division of Vital funeral director, 25. Was case referre o j-dic examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death.

Director: / 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Robert Birschbach,

MAY 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signature

DHMH 17 Rev 1/2001

201 Russell

29c. License number

Avenue, Gaithersburg, MD

29d. Date signed (Month, Day, Year)

20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month April 27, 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 P.M Detlev Volker Hauck /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Angels Garden Assisted Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□ F 90 March 20,1918 147-05-2406 New Jersey Director Usuai Residence of Deceden filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notifled at 1 XYes 2 No Montgomery Rockville Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 United States 4101 Bel Pre Road Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X∑Yes 2 □ No If Yes, Give WW II Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Post Office Utility Clerk Pages 1 and 2 should be filed innent of Health and Mental Hygint: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Agusta Helena Moser Adolf William Hauck ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once. 5205 Coffeetree Drive, Raleigh,NC 27613 Monica Hauck Lavery/Daughter 20b. Place of Disposition (Name of Cemeter) crematory at other place); ty Medical Center April 27 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. Funeral Service License nature 9013 Annapolis Road, Lanham, MD 20706 -23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Day **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 Years Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE: use yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day signed by the atter in the past 12 months? 5 ☐ Other (specify) P.O. I 2 No 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Alzheimers Type Dementia been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy perfor 2∐ No 1∏ Yes Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient c To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 30. Name and address of person who completed cause of de (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAY 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ivan Lee Johnson, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day May 10, 2008 Jr. Medical Examiner Ivan Lee Johnson, 0542 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton Cecil 5. Social Security Number 6. Sex If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year Foreign Maryland Months Min. Director Days Hours 01/13/1957 218-70-3664 1X M 2 F Usual Residence of Decedent 'n 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No E1kton 28a-f show Ceci1 Maryland or items 23a or 28a-f sho must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21921 181 Hollingsworth Manor Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White 4 X Divorced "natural". Widowed If Yes, Give Year Yes 2 X No specify Specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygene.
Important: If item 27 is marked other than "nattinguy or other traumatic event, the Medical Examinguy or other traumatic event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Welder Welding 11 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Ivan Lee Johnson Mary Palette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greggory L. Johnson/Son 181 Hollingsworth Manor, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State R.A. Ferris & Co., Inc. May 16, 2008 West Chester, PA Donation 5 Other Specify: 21. Signature of Funeral Service License 22. Name and Address of Eacility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Alcohol and fentanyl intoxication and cocaine use Death Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical W UNPENDED ned by the attending physician detached for use as the burial #ENFII,27,28a-f, perME,g879 5/21/08 TT To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funcaral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 V Unknown Cirrhosis of liver; diabetes mellitus leted 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other-DOA Nursing Home 5 Residence 6 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Yes 2 X No unk Fnd 5/10/2008 Fnd 5:00 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 <u>X</u> Could not be 124 Pheasant Dr. Elkton, MD (Specify) single family residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 10, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

			For State Registrar	State of N	Maryland		artmen rtificat			and M		Reg. No. 🤌	108	15932				
2)	Physici /Medic		1. Decedent's Name (First, Middle, Last) Doris Marie Karc								2. Date of De Month April	ath 30 , 200	3. Time of Death 6:10 A M					
)	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cou Dove House 5. Social Security Number 6. Sex 7. And (In vrs. last hirthday) If Under 1 Year 1 Year 1 Year 1 Year 8. Date of Birth								Carro	9. Birthr	place (State or Foreign					
			215-12-8621 Usual Residence of Decedent]M 2 X F	86		Months	Days	Hours	Min.	Nov 14	y, Year) • 1921	Mary	land				
Baltimore, Maryland 21215-0036	a-f show	ctor	10a. State 10b. County PA York			, Town or Lo	ocation						-3/	10d. Inside City Limits 1 ☐ Yes 2 🙀 No				
	with the	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Company 4810 Rocky Road 17329								What Coul	ntry?						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	3. 13.		dent of Hi cify Cuba			ecify Yes or No Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White								
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	ind 2 shou alth and M 27 Is mai		19a. Informant's Name/Relationship (Ty Robert W. Karcher/								al Route Numb 11e, PA	er, City or Towi	n, State, Zij	o Code)				
	Pages 1 a nent of Hea nt: If Item nry or othe		20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 05/01/08							20c. Location - City or Town, State Beltsville, MD								
	permit. Departm Importa any Inju		21. Signard of Funcial Service Licenser Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 2102															
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Division or Vital Records, P.O. Box 6	the death certifica y the attending ph ched for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	11 II ive hirth 21 Fetal death 31 Fetonic pregnancy								ate of delive	very Day Year					
	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions co	cant conditions contributing to death but not resulting in the underlying cause given in Part I.								Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown						
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		tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ER/Outpatie 28b. Time Injury		28c. Injur Wor	er: 4□N	ursing Ho	th (Check only one) ome 5 □ Residence 6 Mother (Specify) H CS p in 28d. Describe how injury occurred									
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	To the To the Comp	Me	0.11 - 4 N: 0.10								ed (Month, Day, Year)							
ع)) o 2-		30. Name and address of person who c	ompleted cause	of death (Item		Print)	2	DR	\	rest			mp 21157				
	St Regist	ate rar	31. Date filed (Month, Day, Year)	108 32. Jeg	gistrar's Signa	ture	books	,										

DHMH 17 Rev 1/2001

Christopher Alan L	1	ris State (- For State legistrar	of Maryland / De	epartme C <i>ertifica</i>			l Menta	ıl Hygie		. N o.	200	8. 1	593.
Physician	/	Decedent's Name (First, Middle, Last)					Mo	ate of Death onth	Day	Year	3. Time of De 1744 hrs	
Medical Examine		Christopher Al	an Lewis		E.			Ma	y 9, 200	3	ounty of Death		S
	4	4a. Facility Name (if not institution, give Union Memorial Hospital	street and number)		46	Baltimore	ocation of L						
Funeral	(5. Social Security Number 6. Se	7. Age (In y	rs. last birth	day)	If Under 1 Year	If Under 2 Hours	24Hrs. 8. [Min.	Date of Birth	(MM/DD/	YYYY) 9. Biri Foreig	thplace (State	or
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21215-0036 Juld be filed within 7 Mental Hygiene. In marked other than ic event, the Medica	ן ע	Alan Lewis 19a. Informant's Name/Relationship (T	uno Print \	1 10h	Mailing	Address (Stree			ggins	ner City	or Town State	Zin Code)	
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e, N 1 and 3 Health item 3	T	20a. Method of Disposition	[2	20b. Place of	Disposit	tion (Name of cer er place)		Dat			ation - City or		
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Baltimore, MD semit Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	- 1	21. Signature of Funeral Service Licen	see			ame and Address		Marzi	1110	Fune	eral (Chapel	.P.A
	1	Michael P. Mar 23a. Part I. Enter the disease, or compo	gulla lications that caused the d	leath. Do no	600 enter th	9 Harf	ord I	Road,	Balt Diratory arre	imo	re, Maj or heart	rylanc Approxima	121214 Ite Interval
Physician /Medical	1	failure. List only one cause on ea	^{ch line.} Alcohol, cocai									Detween	Onset and ath
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W g g g	edical Examiner	events resulting in death) Last d.	Due to (or as a consequer	nce or):									
te be executed sysician and thursit	dica	X UNPENDED	#63a,27,28a-f	, perME	.,g879	5/23/08	ГТ						
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy				pregnancy			Date of deliver	ry Day	Year
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	past 12 months?	4 Pregnant at time	of death 5		aldeath 3 ner(Specify)	Ectopic	pregnancy		1 "	Onto	Luy	
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Divisior Hospital or Attend 24 hours after death Funeral Director:		29a. Certifier 1 Certifying Physic	ian: To the best of my kno	owledge, dea	ith occur	red at the time, d	ate and plac	ce, and due	to the caus	e(s) and	manner as sta	ated.	
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examine	r:On the basis of examina and manner stated.	tion and/or in	rvestigat			curred at the	time, date				-3
	Σ	29b. Signature and title of certifier	- N. O			29c. Licens					ite signed <i>(M</i> 10, 2008	onth, Day,Yea	ar)
		COULD OF	sampleted suice of death	(Item 22a)		0.0.		-		ividy	. 5, 2000		
		 Name and address of person who Tasha Greenberg MD. 	completed cause of death Assistant Medical E		111	Penn Street,	Baltimor	re, MD 2	1201				
Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's S	ignature	has	le le							
Registr	ar	MAI TO SOC	- Justine 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 25^{Day} 2008 12:25 PM April Johnny G. Lough 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1**∑**M 2□F Months 28, 1926 81 Dec. West Virginia 216-24-7380 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 □ No Bel Air Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 20 Lake Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1945-46 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Maryland State Police Lieutenant Colonel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Spitzer Leason Lough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21014 20 Lake Dr., Bel Air, MD Loteze Kadlec Lough/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-30-2008 Rising Sun, Maryland Brookview Cemetery 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, 21911 uchand 23a. Part]. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) severe Due to (or as a consequence of): Prieumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Primonary Embeli Sm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No myocardial 24a Was an autopsy performed? /es 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Injury or other traumatic event,

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Director

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Completed

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burial-transit After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Completed by

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Certification: To

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IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

10 Yes 26. Place of Death Check onl one

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation 6 ☐ Could not be

determined

Hospital:

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) April 25,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pper Chesapeake Dr. Bel A.C. MD 2194 500 U m.0

31. Date filed (Month, Day, Year)

APR 2 9 9 2008

Registrar's Signature

DHMH 17 Rev 1/2001

15\$1VA

			1 - For Amend Item	State on 5 per i	of Maryland	d / Depa),05<u>/</u>2 /	artment of F	lealth and l Death		giene Reg. No.	nna	15935
			Decedent's Name (First, Middle)	e, Last)					2. Date of De	ath		3. Time of Death
	Physicia		Robert			Leu	115		April	24	2008	170/ M
	/Medic		4a. Facility Name (If not institution	a. aive street and nu	ımber)			r Location of Death	1	4c. Co	ounty of Death	
	Examin	er	University of Ma			ton	Bultim			Ba	ltimore	
	Funeral			6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	lace (State or Foreign
	Funeral Director		197-36-6001	1 ∏ M 2□ F	58	Yrs.	Months Days	Hours Min.	(Month, Da 8/13/19	y, <i>rear)</i> 49	Cour	Chester, PA
r			Usual Residence of Decedent									
	/land		10a. State 10b. County		1 .	/, Town or Lo					1	0d. Inside City Limits
	Man fied	to	PA Cheste	er	Li	ncoln	Universi	ΣY				1 ☐ Yes 21 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cour	ntry?
	3a o		106 Galloping	Hill Roa	ıd		1935	52		US		
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	Funeral	11. Marital Status		cedent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14	. Race - Americ Black, White,	
0	r Ite	Ξ	1 ☐ Never Married 2 ☑ Marr	ied 1 ☐ Yes	2 🔀 No		1 ⊡ Yes 2⊠ No	Specify:	to Fildan, etc.)			white
3	urs a al', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	Dates:		1 1es 223110	эреспу.		3	pecify:	wiiice
3-003e	72 ho	Completed	15. Deceden (Specify only highe	t's Education)	(Give	dent's Usual Occup	during most of wo	rkina	16b. Kind	of Business/In	dustry
<u>``</u>	hin 7	ple	Elementary/Secondary (0-12)		/ (1-4or 5+)	life.	DO NOT use retire	d)	9			
7	filed within Hygiene. other than "	Š	12			TRU	CK DRIVER				JCKING	
	be file Ital Hy Id oth event	Be (17. Father's Name (First, Middle,	Last)					ne (First, Middle		urname)	
<u>a</u>		To	RAY LEW	IS				C	ORA CAN	rer ———		
Maryland	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relations	hip (Type, Print)			ng Address (Street					
	and 2 saith 27 i	1 8	JOYCE LEWI	S - WIF	E	106	GALLOPING	HILL RE	, LINCO			Y, Pa 19352
more,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition	0 - 16		lace of Disponentery, cre-	sition (Name of matory or other pla	ce)	Date		tion - City or To	
Ĕ			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		LONG	GWOOD	CEMETERY	4/2	9/08	KENNE	rt squai	RE, PA
a	permit. Pag Department Important: I any injury o		21. Signature of Funefal Service	Licensce	- 000	0442 F	Name and Addre	ess of Eacility			III CC	
ñ	Der Bright		1- Cole T	m	\	2	OO ROSE F	HILL RD,	WEST GRO	OVE, I	PA 1939	0
h	*		23a. Part1. Enter the disease, o shock, or heart failure. Lis	complications that	caused the deat	h. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final	200	The Cartes Control of the		natoma					Onset and Death
	/Medical		disease or condition resulting in death)		o (or as a consequence		naioma				7	unity days
	Examiner									/	1	
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a conseq	uence of):			العود ١	M	ER	
	uted J ansit	ä	cause. Enter Underlying Cause (Disease or injury that initiated events					1 R	NED!	FAL EXAMI		
,	exec n and ial-tra	Examiner	resulting in death) Last	CDue to	o (or as a conseq	uence of):		101/04	PPROVED BY	7		
8/60	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	lical		d				CENTIFICATION				
9	ficate g phy is the	edic		0.								
X Q Q	leath certifica attending ph I for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna		7			23	d. Date of deliv	ery
ň	atte atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2□Feta gnant at time of d		⊒Ectopic pregnand ⊒ Other (specify) _	У			Month	Day Year
o	at the de by the a	ıysi	9 Unknown	9□Unk	nown							
1	res that signed b be deta		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	ınderfying cause gi	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
Vital Hecords,	uires sign Id be	d by							1 🗆	Yes 2	No 3□ Pro	bably 4 Unknown
ਨ੍ਹ	v require been sig should b	Completed							24a. Was	an	24h Were aut	opsy findings available
ě	ne lav has je 2	ם							auto	psy prmed2	prior to co death?	ompletion of cause of
<u></u>	r: Th icate								1□ Yes	2 ™ No	1 ☐ Yes	2 No
<u> </u>	s lcian: The certificate hir rector, page	Be	25. Was case referred to medica examiner?	Hoepital			nt 3 DOA Ot	nor:	ath (Check only			
Ö	Phys this	은	1 res 2 No 27. Manner of Death		Inpatient 2 ☐ e of Injury	28b. Time of	III 3 DOA	4 🗆 Nursing	Home 5 ☐ Res 28d. Describe			ify)
Ĕ	ing l	Ö	1 □ Natural 5 □ Pendi	ng (Mc	onth, Day Year)	Injury	Wo	rk? Yes 2 ∐ No				A
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DIVISION OF	or A	Certification:	4 ☐ Homicide determ	bui bui	lding, etc. <i>(Speci</i> i	fy),	root, ractory, office		City or To	wn, State)		maryana
_	pital urs a arai (200 Contil	ng Physician: To t	rking la		th occurred at the	ime data and plac				rard County
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	(Check only 2 Medica	Examiner: On the	basis of examina	ation and/or i	nvestigation, in my	opinion, death oc	curred at the time	, date and	place, and due	to the cause(s)
	the the The	Med	29b. Signature and the of certific		anner stated.		29c. Licen	se number		29d, Date	signed (Month	. Dav. Year)
	Wit Coi	5	290. Signature and artier of certific								24,200	
	1/		1100	פחן				4635		MD C. C	21,200	
	15	1	Name and address of person	who completed ca	use of death (Iter	n 23a) (Type	, Print)		1- 4			
	V		Robert S. Stephens	MD 22	- South Gra	enc St	rect Balk.	more Mo	ryland	2120	!	
	Sta		31. Date filed (Month, Day, Year	2008	registrat s Signi	8 4	met .					
	Regist	CII.	HIT TO			-						

DHMH 17 Rev 1/2001

			1 - For Amend Ite	ns 23a,25,	Marylan 27,28	d / Depa a-f pe	artment of H Tificate of t	lealth and N 05/13/0 Death	Mental Hyg 8dhb	giene [] [08 159	35
			1. Decedent's Name (First, Middle,						2. Date of Dea Month		3. Time of De	eath
وله د	Physici /Medic	70	SUSAN MURPHY	Z					MARCH	26 20	008 7:11A	М
r	Examin	- 4	4a. Facility Name (If not institution, g					Location of Death	1	4c. County		
	- 4		PRINCE GEORGE			last birthday)	CHEV.	ERLY If Under 24 Hrs.	9 Date of Bird		SE GEORGES	
	Funeral Director		5. Social Security Number 229-68-8354	1□M 2□F	58	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day 6/5/19	, Year) 0.49	Birthplace (State or F Country) VIRGINIA	
X	ab		Usual Residence of Decedent		30				10/ 3/ 2.			
	nylan how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City 1 X Yes 2	
	Be-f	Director	MD PG_		MIT	CHELL	VILLE_			10. 02		
	ath with the Marylan 23s or 28e-f show	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of W		
	death with the Maryland rms 23s or 28e-f show rmst be notified at	rai	1709 CRIMSON	PLACE 12. Was Decede	nt Ever in II	S 13	20721 Was Decedent of H	lispanic Origin? (S	nectiv Yes or No-	U.S.	- American Indian,	
	Item Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Armed Force	s?		If Yes, specify Cuba	an, Mexican, Puer	o Rican, etc.)	Blac	k, White, etc.	
99	urs af	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2X No	Specify:		Specity	BLACK	
2	filed within 72 hours after des Hygiene. other than "natural", or Items ont, the Medical Examiner m	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup	during most of wor	rking	16b. Kind of Bu	siness/Industry	
7	ithin Nec	Jqr.	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retired	d)		REAL I	ESTATE FIF	n.r.
2	ill Hygier other th		1.7. Father's Name (First, Middle, La	net)		REA	L ESTAT		ne (First, Middle,			7.1
aryland	d ta b	o Be	AUSTIN TAYLO						CARTE		,	
2	should be ind Menta i marked umatic ev	F	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Number or Ru	iral Route Numbe	r, City or Town,	State, Zip Code)	-
Σ	d Z		TRACY MURPHY/	DAUGHTER		1709	CRIMSO	N PL. M	ITCHEL	LVILLE	MD 20721	
more,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place		Date		City or Town, State	
Ē			1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	icify)	СН	ESAPE	AKE CRE	M. 4/7/			ILLE,MD	
alt	permit. Pag Department Importent: i any injury o once.		21. Signature of Funeral Service Li			2:	2. Name and Addre	ss of Facility ST	RICKLA	ND FUNI	ERAL SERVI	
m	20129		exemple)	Stowart	**	6	500 ALL	ENTOWN	RD. CA	MP SPR	INGS MO	2074
В			23a. Part1. Enter the disease, or shock, or heart failure. List or	omplications that cau nly one cause on eac	h line. Su	bdural	Hematoma	complic	eating In	ntra-	Interval Balwe	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a 5	00	nas	2777	erebral	Hemorrha	age //	A STAMINER	
Н	Examiner			Due to (or	as a gonseq	uence or):	116		1/1/1	OBE	MEDICA EXAMINER	
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8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d. —	an	elay	Pany	was	David -	Congli	a Herrory	uga
9 xo	leath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ancy	,			22d Day	te of delivery	
Bo	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birtl	n 2 Feta	ıldeath 3[□Ectopic pregnancy □ Other (specify)	У		Mo		ar
o.	that the de led by the a detached t	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9☐Unknow								
S,	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Dther significant condition	s contributing to deal	th but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use cont	nbute to the cause of dea	ath?
rds	w requires been sign should be		Hyper	Cepron	(Geo	-1	11		10`	Yes 2□No	3 Probably 4 Dun	known
Record	e law requ has been ge 2 should	plet	Attina	1 Fr	lon	lle	alson	7	24a. Was	an 24b.	Were autopsy findings av	allable use of
	The ate h page	Completed	Charles	me	-				✓ perfo	rmed? 2 □ No	death? Yes 2□No	
Vital	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?			7	T 011		ath (Check only o	one) /		
of	Physic this c	은	examiner?			ER/Outpatie	nt 3 DOA Oth	4 Nursing r	dome 5 Resident	dence 6 Oth		
U.C	ding Ph h. After th funeral	on	27. Manner of Death 1 Thatural 5 Pending	tion - Court	Day Year)	Unkno	Wor	rk? Yes 2X No		et fell.		
Division	r Attending Physician: er death. rector: Atter this certific by the funeral director,	ertification:	2 Accident investiga 3 Suicide 6 Could no	U3/1//	2008 I Injury - At h		WII		28f. Location (Street and Numb	er or Rural Route Numb	Br,
<u>≤</u>	after after I Dire	erti	4 ☐ Homicide determin	Bus S	, etc. <i>(Specii</i> S top	fy)	reet, factory, office		Mitche	wn, State) 211ville	, MD	
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	the Hos in 24 h the Fur pletely	edical	one)	and manne			nvestigation, in my o	opinion, death occi		date and place,	and due to the cause(s)	
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medic						opinion, death occi		date and place,		
)	To the Hos within 24 h To the Fur completely	Medio	29b. Signature and title of certifier	and manne	r stated.	ation and/or in	29c. Licens	opinion, death occi		date and place,	and due to the cause(s)	
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	To the Hos within 24 h To the Fur completely	2	30. Name and address of person w 31. Date filed (Month, Day, Year)	and manne	r stated.	m 23a) (Type	29c. Licens	opinion, death occi		date and place,	and due to the cause(s)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear Physician Nora Jincy Rutherford Mathews 2008 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner TIOCC 1-tame Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yos. last birthday **Funeral** Hours Country) Virginia Months 1 □ M 2 F 105 Director 228-10-5236 Feb. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1501 Bayview Drive 21078 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 72 hours after ☐Yes 2 Yes, Give 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Six Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F Lum Christopher Rutherford Addie Blevins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Susie M. Fay (Daughter) 1501 Bayview Drive, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Glade Valley Cemetery 05/03/08 Glade Valley, North Carolina 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licer Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last physician and Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 DHNo Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 | Yes 2 No 3 | Probably 4 | Unknown been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has l autopsy performed? res 22No certificate 1∏ Yes or Vital Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: No No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Division or Attending Injury 1 Matural investigation 1 ☐ Yes 2 ☐ No death. To the Funeral Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide Hospital within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ulugn

Registrar

State

LETTUA

31. Date filed (Month, Day, Year)

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EZ,

5. GALV

APR 2 9 2008

S-UNION SIE HAURE DE GRACE ND 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per of health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HENRY MORGAN 9:00 AMES APRIL 28 2008 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 705 Americana Drive, Apt. ANNAPOLIS ANNE ARUNDEL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security **4004** 216–16–4006 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 → M 2 □ F 84 Months Hours 1923 Pennsylvania Director Nov. Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. M 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Eventiner must be notified at Anne Arundel Annapolis Maryland Director 1XX es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 U.S.A. 705 Americana Drive, Apt. 37 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1943–45 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🗷 No Specify: þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Tax Preparation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Dennison Morgan Beatrice Rose Hewitt ပ permit. Pages 1 and 2.
Department of Health an Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Morgan, III 17 Sampson Place Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/1/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licer/see Mich 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician MILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi 5ch4mic YEAKS CARDIOM 40PA and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical CONDESTIVE MEART FAINRE IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated

Division of Vital Records, Hospital or Attending Physician: thin 24 hours after death, the Funeral Director: Aft mpletely filled in by the fun To the I within 2 To the I

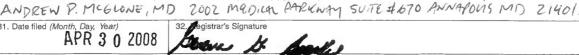
Baltimore, Maryland 21215-0036

P.O. Box 68760.

Registrar

31. Date filed (Month, Day, Year) APR 3 0 2008

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0062349

29d. Date signed (Month, Day, Year) APRIL 29 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 08 **Physician** Joan Elizabeth McGeehan 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7. Age (In yrs. last birthday) Year I If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 T 73 218-30-7374 19,1934 Maryland Director Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Severna Park MD Anne Arundel 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21146 304 White Plains Court Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify Specify: þ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Home** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Burkowske Charles Kassakatis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark William McGeehan/ son 1034 Skyview Drive Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Baltimore, Maryland Loudon Park Cemetery 4 Donation 5 Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 W Funeral Service Licensee Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Canler /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 090 Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🗽 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 MInpatient P Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Accident Injury 5 ☐ Pending investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760 Division or Vital Records, P.O.

physician and the burial-transit as nse ō ed by the a detached f signed by t d be detach After this certificate has been si funeral director, page 2 should I I or Attending Physician: after death. To the Hospitar c. within 24 hours after death.

To the Funeral Director: After a contact of the Funeral Director.

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ral", or items 23a or 28a-f shov Examiner must be notified at

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purmit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'arry Injury or other traumatic event, the Me

the Medical

Baltimore, Maryland 21215-0036

Medical State

31. Date filed (Month, Day, Year) APR 3 0 2008 Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 4659

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

- My tun C.

32 Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) 2008



30. Name and vidress of person who completed cause of death (Item 23a) (Type, Print)

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thony McDonald		State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death		201	J8 1594
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edical Examine		Anthony McDonald 4a. Eacility, Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 4, 200	4c. County of Death	
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Maryland 28a-f show datonce.		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Re				- 7in Codo\ 20032
21 ould 1 d Mer s mar	₽Г	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Assert Value of Street and Number or Assert Value of Street Value of Street Value of Street Value of Street Value of Street Value of Street Value of Valu	Rural Route Num	101 Washin	gton, DC
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	L	20.0229	Date	20c. Location - City o	
G, lead Heal	1	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	200. Zooddon Gry	
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other Specify: Harmony Mem. Park 5-1	0-08	Landover,	MD
nit. Partme			tewart F	uneral Hom	e, Inc.
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	le	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
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Division of Vital Records, P.O. Box within 24 hours after death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternate of the funeral director, and the director, page 2 should be detached for the completely filled in by the funeral director, page 2 should be detached for the detached for t	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d at the time, date	e and place, and due to	the cause(s)
To To	ĕ	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (i	Month, Day, Year)
		Care of x fa o O air O.C.M.E.		May 5, 2008	
	ļ	30. Name and address of person who completed cause of death (Item 23a)			
0		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
_		32 Registrar's Signature			
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	tems er mi	Funeral	11. Marital Status 12. Was Decede Armed Force	es?	Was Decedent of His f Yes, specify Cubar	spanic Origin? (\$ n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fi	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	1 1	I∐Yes 2∭INo	Specify:		Specify: W	hite
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Ž	and 2 ealth a 1 27 ts		William F. Noyes/Husband	634	Little Eg	ypt Rd.	,_Elkton,	MD 2192	1
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0	ding Ph J. After th funeral	T:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month,	Injury 28b. Time of Injury	28c. Injury Work			w injury occurred	00.177
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	(Check only one) 2 Medical Examiner: On the basi and manner	s or examination and/or inv r stated.					
	To To con	2	29b. Signature and title of certifier	1 12	29c. License	number	14	9d. Date signed (Mor	nth, Day, Year)
•	.1		30. Name and a dress of person who completed cause of	of death (item 23a) (Tyres	Print)	7 /	1 / 1	pr. /25	,2008
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 26, William J.C. Neaves 2008 9:25a April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital Elkton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year)
Tanuary 27, Ceci1 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1939 Months 197 M 2□ F January Director 221-24-9598 69 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show be notified at 10a, State 10b. County 10d. Inside City Limits 1 XYes 2 No Director Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a dical Examiner must b 115 Beech Drive 21921 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Way Yes 2 □ No 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1950's 1 ☐ Yes 2 ☐ **X**o White 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland Cork Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental Hitem 27 is marked out Pages 1 and 2 should be Roy Lee Neaves ျှ Carrie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Neaves/Daughter Elk Chase Drive, Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott May 1, 1X Burial 2 □ Cremation 3 □ Removal from State Elkton Cemetery Elkton, MD 4 Donation 5 Dother (Specify) 2008 21. Signature of Europa Service Licensee 22. Name and Address of Facility
Andrew G. Gee Funeral Home 259 East Main St., F1kton, MD shock, or heart faller. List only one cause on each line. 21921 Immediate Cause (Final Recurred Anaplastic **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician by Physician/Medical the as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Ďav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an page 2 autopsy performe certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number

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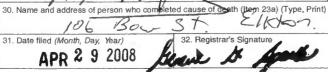
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Registrar

31. Date filed (Month, Day, Year) APR 2 9 2008

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29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 **Physician** 4:54 P M Vaughn Gilbert O'Hara 23, April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bowie Health Care Center Prince George's Bowie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**XX**M 2□ F Months Hours Director 80 168-22-0607 July 27, 1927 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Prince George's Maryland | Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13004 Forest Drive 20715 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [Xyes 2 □ No If Yes, Give Year or Dates: 45 - 153 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director of Intelligence Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Daniel O'Hara Ernestine Marie Roble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Ann O'Hara/ Wife 13004 Forest Drive Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/1/2008 Crematory Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** who scarde /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 62/500-0-Open-9 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2/2 No 1∐ Yes al or Attending Physician; after death. I Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar Dan (2)-

31. Date filed (Month, Day, Year)
APR 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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Amend Item 23d 25 per me 9879 05/14/08dh Pleath and Mental Hygiene

1- AMEND#4cperMD 5-1-08; BW; Many Mental Hygiene

1- Registra/MEND#23e, 24a/b, 23a(d)perMD4-29-08; BW Militicate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 18tu 212 Shabani 8-45-pM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing Home Columbia If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**万**M 2□ F Director 88 January 1, 1920 Iran 174-60-7573 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zîp Code 10018 Vanderbilt Circle, #4 20850 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Soleiman Shabani Goli Mordechai ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9768 Athletic Way, Gaithersburg, MD 20878
of Disposition (Name of Date 20c. Location - City or Town, State Laleh Shabani (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Falls Church, VA $4 \square Domation 5 \square Other (Specify)$ King David Cemetery 4/22/08 21. Signat e of Funeral Service License 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Fa/11s Church, VA 22046 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flear failure. List only one cause on each line. s ock, or heart failu Iron ediats Cause (Final disease or condition resulting in death) ca patitos Interval Between Onset and Death Atrial **Physician** BY MEDICAL EXAMINES /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICA Examine attending physician and for use as the burial-tran The law requires that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Quadriplegia following Cervical Spine Surgery Physician/Medical for Cérvical Stenosis 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy 2X No Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2∏ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA e Hospital or Attending Pt 24 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Lîcense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 34974 cprienta pro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARUMEHTA, MD, 8775, dendleah ct, # 224, cohimbia, M & 21045 31. Date filed (Month, Day, Year) APR 2 9 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MMA STRUGLINSKI 12:28 AM 10 MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Klein Hospice Frederick Mt. Airy Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🗓 F January19,1921 Director 288-18-0168 87 Ohio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10931 Green Valley Road 21791 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🟋 ☐ No Specify.White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry es 1 and 2 should be filed within of Health and Mental Hygiene. I item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Tire Manufacturing Nurse permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephen Paul Elizabeth Serr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2,1,7,9,1 19a. Informant's Name/Relationship (Type. Print) 10931Green Valley Road, Union Bridge, Maryland Linda Harley /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Murial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 5-16-08 Wadsworth, Ohio 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A. michael P Road, Baltimore, Maryland21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. no Ke Immediate Cause (Final **Physician** 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran and Due to (or as a consequence of): attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? P.O. I signed by the at Id be detached for 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by DISEASE ARKINSON & 1 Tes 2 No 3 Probably 4 dnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

MA

M.D

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

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29d. Date signed (Month, Day, Year)

Thurmout MO 21788

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о В	deat e att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)	y -			Me	onth	Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** John C. Van Hoesen April 25, 2008 9:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year | If Under 24 Hrs. Social Security Number
 215-20-3319 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 11X M 2□ F Days Director 82 09/17/1925 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at MD Montgomery Damascus 117 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26840 Howard Chapel Drive 20872 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1X1Yes 2 □ No 1943-If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ Specify. 3 ☑ Widowed 4 ☐ Divorced 1946 Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Funeral Service Elementary/Secondary (0-12) College (1-4or 5+) Funeral Director Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental P Important: If Item 27 is marked oil any linjury or other traumatic ever once. Pages 1 and 2 should be f nent of Health and Mental I Garrett Van Hoesen Lillian Gewher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth L. Van Hoesen / Son 26840 Howard Chapel Dr. Damascus, MD 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 04/30/2008 Falls Church, VA National Crematory 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, transcriptions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the ar Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DERTENSLOW 3 Probably 4 Unknown 1 ☐ Yes 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed HUPERLIPINEMA Division or Vital 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ို 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Man, er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature ar 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and ad

2. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

Rd. Chanotte Hall MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1325 P^M Apri1 25 2008 Charles White, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Chesapeake City 15 Buddy Blvd. Ceci1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Pennsylvania 188-42-6086 Director Feb. 7, 1953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show aţ 1 ☐ Yes 2 X No Examiner must be notified Director Chesapeake City Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 15 Buddy Blvd. 21915 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married ō 1 ☐ Yes 2 X No Specify: White Specify þ 3 Widowed 4 Divorced Year or Dates: Vietnam "natural", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles White, Sr. 2 Delores Dragani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) riportant: If item 27 Marlene White/Wife 15 Buddy Blvd., Chesapeake City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4-29-2008 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part1 Enter the disease, or complications that cau led the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and is the burial-trans Due to (or as a consequence of): Physician/Medical as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has le 2 autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 \sum Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Injury 5 Pending investigation 2 Accident To the Funeral Director; completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License numbe 29b. Signature and title of cartifier 29d. Date signed (Month, Dav. Year)

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within 72 hour: after

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Maryland

Baltimore,

Pages 1

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

To the Hospital

hours after death.

within 24

State Registrar 31. Date filed (Month, Day, APR 2 9 2008

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36. Name and address of person who completed cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician April 28 Day 2008 ear 5:20 р м William Connell Walker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Nursing & Rehab. Center Kensington Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 28, 9. Birthplace (State or Foreign **Funeral** Year) 1942 California 1 3 M 2 □ F 093-32-3217 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show 1 ☐ Yes 2 No Directo Hyattsville Maryland Prince George's death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Evander Course. 20783 USA 7403 18th Avenue, Apt. 102 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white If Yes, Give Year or Dates: Specify: Completed by Specify. 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Musician Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Bird Walker Nancy Connell Kaye ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Ibarra/Step-Sister 3890 State Rte. 30, Middleburgh, NY 12122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date April 30 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MELANOMS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and leading to important cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy 2/☐No 1 □Yes 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

al or Attending Physician: 1 s after death. Il Director: After this certifica ed in by the funeral director, p

completely filled in by To the Hospital of within 24 hours at To the Funeral D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00057124 4119108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, MD 9715 Medical Center Drive, Rockville, MD 20850 Truong Bao, MD 31. Date filed (Month, Day, Year) 324Registrar's Signature

State Registrar

Medical

29a. Certifier

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2008 Month Tillie ZELKOWITZ **Physician** April 28, 2:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 051-10-1653 7. Age (In yrs. last birthday) 91 vrs 8. Date of Birth (Month, Day, Year) Aug. 11, 1 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 X I F 1916 Massachusetts Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d, Inside City Limits show f Heath and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Rockville Maryland Montgomery 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20852 United States 6105 Montrose Road #390 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Tarlow Rachel (unknown) ၉ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10058 Cotton Mill Lane, Columbia, MD Department of Health a Important: If Item 27 Is any injury or other tra Marvin Zelkowitz, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eternal Light Cemetery 05/01/08 Boynton Beach, FL 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW. Washington, DC 20012 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HROMBOSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Veal Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours after death. e Funeral Director: A completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated. To the within 2

State Registrar 29b. Sign

ature and title of certifie

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31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) Type, Print)

2008

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

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Physici /Medic		1. Decedent's Name Edwar	(First, Middle, La	,							2. Date of De Month April		2008	3. Time of Death 7:30 A	M
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Dallimore Dermit. Pages 1 Department of He mportant: if iten any injury or oth		20a. Method of Dispo 1 X Burial 2 ☐ 4 ☐ Donation 5	Cremation 3 [n State	b. Place of D cemetery, [aryla:	orematory nd Ve	or other place terans	3	1ay 5 2008		Crown	svill	Town, State e, MD	
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Porton, cate be executed /Medical Examiner ethe burial-transit the burial-transit	dical Examiner	a. Part1. En er the shock, o heart Immediate ause (Fills or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underscause. Enter Underscause in that initiated events resulting in death) La	failure. List only nal	a. Non Due to	sach line. Small o (or as a con: o (or as a con:	Ce11 1 sequence of)	ung :			cardiac	л гезрпакогу а	11651,		Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	1 ☐ Live	utcome pf pre birth 2 DF gnant at time	etal death	3 ☐Ectop 5 ☐ Othe	ic pregnancy r (specify)	<i>y</i>			23d	. Date of de Month	livery Day Year	
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tal or Atter rs after dea ral Director led in by the	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	28e. Plac buil	ce of injury - A ding, etc. (Sp	t home, farm ecify)	, street, fa	ctory, office		2	28f. Location (: City or To	Street and N vn, State)	lumber or R	ural Route Number,	
the Hosp in 24 hou the Funer pletely fill	Medical	29a. Certifier 1 (Check only 2 one) 2	Certifying P	miner: On the	ne best of my basis of exan unner stated.	knowledge, on and/	death occu or investiga	tion, in my o	opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) an date and pl	d manner a ace, and du	s stated. e to the cause(s)	
0 1	Σ	29b. Signature and to	le of certifier		MD	•		29c. Licens D356					igned (Mon 130 ,	th, Day, Year) 2008	
41		30. Name and address Dr. Josep				Item 23a) (Ty		illip	Drive	#32	7 01ne	ey, MD	. 208	32	
Sta Registr		31. Date filed (Month	, Day, Year) AY 0 1 2	2008 32.	gistrar's Si	gnature	Spens	Ð							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2008 Santosh Arya May 14, 2:35 A. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 1 F 156-94-3878 70 June 05,1937 Amritsar, India Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore County Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 1113 Apt.E Sandy Stone Road 21221 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify. Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home

18. Mother's Name (First, Middle, Maiden Surname)

Essex, Maryland 21221

Forrest Hill, Maryland

Day

Year

Dice

Approximate Interval Between Onset and Death

20c. Location - City or Town, State

Kesra Devi

Sandy Stone Road

May 15,

2008

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print) (Husband)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

<u>Mr. Krishen Chander Arya</u>

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

Bir Chand

20a. Method of Disposition

Director

Funeral

2

Completed

Be

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Funeral

Director

as the

The law requires that the death certificate be executed and the attending physician been signed by should be detact this funeral After death. after death

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

24 hours a

within 2

Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium,Maryland 21093 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause of each line. 23a. Party. Enter the disease shock, of heart failure. Immediate Cause Final disease or condition resulting in death) ischemic End STAGE cardio m Due to (or as a consequence of) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 disense duey 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 3 DOA 1 Inpatient 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1113 Apt.E.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

6 2008 32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kamel Jabapa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ihi

32. Registrar's Signature

201-109

29c. License number

30641

20641 May 12 2008 Rack Rever Neck Road be 1 sme Naglad 2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician ABRAMOVITZ** SIPORA 2:53 P MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JEWISH CONVALESCENT & NURSING BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 3. Date of Birth Month, Day, Year) 7/8/1933 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 ☐ XF 052-44-6543 74 POLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be retified at once. Director 1 □ Yes 🏖 No BALTIMORE BALTIMORE MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 _Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) JEWELRY ASSEMBLER 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be ၉ CHANA UNKNOWN VEINSTOCK UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 JOHNSON ROAD Lagrangeville, NY 12540 OFIRA GOMEZ / DAUGHTER 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MEN CEM. 5/15/2008 BALTIMORE, MD SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Liberage 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 eme 23a. Part 1. Enter the disease complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** March NG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the aid be detached for P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 Yes 2 No 3 Probably 4 No Nown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has perfo 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2XNo Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 2 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person filled (Month, Day, Year) MAY 1 6 strar's Signature State 2008 'Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** MARY AGNES 2008 BLUM MAY 12 6:44 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 3222 ROSALIE AVENUE PARKVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/28/1909 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛛 F 98 217 07 0600 MARÝLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 'natural", or items 23a or 28a-f sho dical Examiner must be notifiled at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3222 ROSALIE AVE 21234 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 LEGAL 4 PARALEGAL SEC. is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental H fitem 27 is marked oth Be CHARLES BLUM ပ ANNA GRANDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN CIOTOLA / NIECE BALTIMORE, MD 21234 3222 ROSALIE AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of H Important: If ite any injury or of 1 → Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH 5/16/08 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fun val Service Licensee 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MESENTERIC ISCHEMIA disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Was an page 2 s autopsy certificate 1 Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State

Registrar

ALEXANDER

P.O. BOX 19099 TOWSON, MD 21284

29d. Date signed (Month, Day, Year)

5/13/2008

CHEN, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D57444

29b. Signature and title of certifier

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			1- For State Registrar		Cer	tificate of	Death				g. No.	form "w" \		
Mo	Physicia dical Exami		Decedent's Name (First, Midd	e,Last)						Date of Deat	Day	Year	3. Time of De 0024 hrs	
Nie	uicai Exami	ner	Doreen 4a. Fadility Name (if not institution		Bennett	- 1.	4b, City, Town, or	Location of		lay 8, 200		ounty of Dea		,
ς .			Civista Medical Cente	-	imber /		La Plata	2004401701	Death			arles		
	Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea	ar If Under	24Hrs. 8.	Date of Birt	h(MM/DD	/YYYY) 9. E	irthplace (State	or
	Director	-	217-72-4122	1 M 2XXF	50	Yrs	Months Day	s Hours	Min.	02 –1 4-	1050	Fore	_{Country)} Wash	, DC
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	v any	Ī	10a. State 10b. County		10c. City,	Town or Locati	ion					•	10d. Inside C	
0	r death with the Maryland or items 23a or 28a-f show must be notified at once.	5		arles			La P	lata					1 Yes	2 X No
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6	th wit	Funeral	11. Marital Status 1 XXNever Married 2 M	arried Armed Fe	cedent Ever in U. orces?	S. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Origi n, Mexican,	n? (Specif Puerto Rica	y Yes or No- an, etc.)	14	 Race - Ame White, etc. 	erican Indian, Bla	ick,
\	er dea			1 Yes	2 XX No	1	Yes 2 X No	s specific				ecify:	White	
	ırs aft ural" mine	<u>\$</u>	15. Decedent's Education (Spe	. or Dates:			t's Usual Occupa		ind of work	done		of Busines		
	2 hou	et e	Elementary/Secondary (0-12)			during m	ost of working life	. DO NOT L	use retired)					
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	5-0036 iled within 72 Hygiene. I other than		17. Father's Name (First, Middle	Last)				18.Mother's	Name (Fir	st, Middle, N	Aaiden Su	rname)		
	121 lbe fi ental l arked	Be	Harry J. Benn						nn Gi					
	D 21 should be and Mer	٤	19a. Informant's Name/Relations		in 1		Address (Stre							
	MD and 2 she salth and em 27 is raumati	- {	Pete Berges 20a. Method of Disposition	- Brother-			Derby Name of ce			ete			or Town, State	
	Ore Ses 1 g		1 XX Burial 2 Cremation	n 3 Removal fr	rom State	crematory or ot	her place)		Mag	У		,		_
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other S			adowric	age Mem.	Pk.		2008			, Maryla	
	Bal permi Depar Impo injur		21. Signature of Funeral Service	Licensee M(00053				Gury				eral Hom	
	Physician		23a. Part I. Enter the disease, or		aused the death.	MMI Do not enter t						lkrido , or heart	Approximat	e Interval
	/Medical	Į.	failure. List only one cause Immediate Cause (Final disease		on and ou	etianino	interior	-ion					Between O Dea	
1	xaminer		or condition resulting in death)		consequence of		HILOXICAL	-141						
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	Box 68760, re death certificate be execute the attending physician and ned for use as the burial - tran	sician/Medical	23b. Was decedent pregnant in t past 12 months?	ne 1 Live t	pirth	2 Fe	tal death 3	Ectopic	pregnancy		М	onth	Day	Year
	OX cath cath cather	Sici	1 Yes 2 No 9 🗸 Un	7	nant at time of de	ath 5 Ot	her (Specify)				11022			
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	ician: The law require s certificate has been si	ပ္ပ						(5	<u> </u>	1 Yes	2 No	1 🗸	Yes 2	No
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	of Vi ing Physi After this uneral dir	£	1 ✓ Yes 2 No 27. Manner of Death	28a. Date		28b. Time of I		ury at Work		d. Describe			ici.	
	nding Ph ith. r: After t	흲	1 Natural 5 Pen	(Month	n, Day,Year)		1 1	Yes 2 X	No.				~~	
	Division of Vital Records, P.O. tal or stending Physician: The law requires that the realite death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ficat	2 Accident Inve	stigation FIIC 3	5/7/2008] se of Injury - At ho	Fnd 11:	UU PIII		S	. Location (Street and	ced druk Number or	Rural Route Nur	nber, City
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State 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001 OCME 2006

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

OCME

May 9, 2008

Physician /Medical **Examiner Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ral", or items 23a or 28a-f show Examiner must be notified at Director Funeral Baltimore, Maryland 21215-0036 "natural", or þ Completed permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other? Be ဥ 5 injury **Physician** /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

attending physician for use as the buria

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 44 19 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Olyuns If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday Date of Birth (Month, Day, Year) Days Hours 1 □ M 226-32-8019 79 VA Aug 29, 1928 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Howard West Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3205 Rosemary Lane 21794 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Telephone Operator** Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester McKinley Frye Pauline Marie Bynaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Austin Frye Brother P.O. Box 318 West Friendship, MD 21794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) May 14, 200B Crest Lawn Memorial Gardens Marriottsville, Maryland 21. Signature of Funeral Se 22 Name and Address of Facility Vice Licensee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. *ote the dis * > , or complications that c shock, or leart failu List only one cause on a d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Due ter(oras a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 ☐ Probably 1 Yes 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 € No 2 2 ER/Outpatient 3 □ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗓 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 492/06/19 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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To the Hospital or Attending Physician;

within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dire

PATIE NT KNGWN 4S JULIUS BROCKINGTON
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

vision of Vital Records, P.O. Box 68760,

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			for State	State of Marylan		ment of H ficate of L			20	08	15959
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i d	within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	ition and/or invest	igation, in my of	oinion, death occur	red at the time, d	ate and place, ar	d due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:00 PM SHACONDA DEVERA BENJAMIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH WEST HOSPICE BALTIMORE CO BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 7 1968 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Director 39 217-90-0598 MARYLAND Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show r than "natural", or items 23a or 28a-f sho the Midical Evan in her must be notified at 1XXYes 2 □ No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1322 WOODYEAR STREET 21217 Funeral U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene.
Important if filem 27 is marked other than "" any Injury or other traumation." 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade MED ASSISTANT HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ DONALD BENJAMIN BRENDA L GROSS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3723 REisterstown Rd., Baltimore, Maryland 21215 of Disposition (Name of Date 20c. Location - City or Town, State Eleanor Gross/Grandmother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 05-19-08 WOODLAWN, MARYLAND 21. Sign are of Funeral Service Dio 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Willera 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage Human Immunodoficiency Vivus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has ral director, page 2 s autopsy 1 ☐ Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD REISTEXISTOWN 5 MAIN STREET 31. Date filed (Month, Day, Year) State 2008 MAY 16 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard 10101 Governor Warfield Parkway Apt #420 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 NY Director Sep 7, 1922 089-12-3672 Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Columbia Howard MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A 10101 Governor Warfield Parkway Apt # 420 Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Exemines once. 1 Never Married 2 Married No Baltimore, Maryland 21215-0036 1 ☐ Yes Specify. <u>6</u> Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Jennie Sollima Joseph Novello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10101 Governor Warfield Parkway Apt #420 Columbia, MD 21044 Thomas Case Spouse Mexicod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) May 10, 2008 Brooklyn, NY St. John's Cemetery 21. Signature of Funeral Strice Linensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City MD 21043 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications the consequence shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and as the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 honths? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 🗆 No 1 ☐ Yes 2 within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manyler of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number (Type, Print) and 31. Date filed (Month, Day, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13% 1570 M **Physician** 127 2007 Virginia Chrzanowski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day.) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Days Hours 1 □ M 2 🛛 F Maryland 81 220-12-7470 Director Usual Residence of Decedent 10b. County N/A 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Baltimore 1 Yes 2 □ No ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified. Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6807 Moyer Avenue 21234 U.S.A. by Funeral within 72 hours after death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer Food Industry permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: if item 27 is marked other this any injury or other traumatic over the statement of 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Ksepka Frances Pieczyska ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6807 Moyer Avenue Baltimore, Maryland 21234 Melvin Chrzanowski- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corporation 05/15/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 21. Signatur of Funeral Service 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, Maryland 21214 horas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det <u></u> 1 ☐ Yes 🍂 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed certificate 1□ Yes Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3□ DOA P 1 ☐ Yes 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Medical Certification: (Month, Day Year) Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continu 1 K tho completed cause of death (Item 23a) (Type, Print) Name and address 0 7333 Worlt (Month, Day, Year) 32 Registrar's Signature 31. Date filed State

DHMH 17 Rev 1/2001

Registrar

MAY 1 6 2008

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Benito Angel Cano May 13 2008 P^{M} 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 12601 Orchard Brook Terrace Rockville Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Jan. 12, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Days Hours Months Min 87 Director 135-42-2164 Spain Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 12601 Orchard Brook Terrace 20854 Funeral United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 0 Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Cuban Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Haberdasher Men's Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julian Cano Augustina Ruiz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau John A. Corso / Son-in-Law 12601 Orchard Brook Terrace, Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 16, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland M01360 Rockville, Maryland 20850–2805 21. Signature of Funeral Service Licenses This the Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Cardiomyopathy 10 years /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus 10 years Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) □Yes 2□No 9 Unknown has been signed 2 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ກ 24 hou₁ູ the Funeral Dire 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 ho

To the Function

completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52382 May 13, 2008 J 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Danilo Molieri, M.D. 4701 Randolph Road #216 Rockville, Maryland 20852 gistrar's Signature 31. Date filed (Month, Day, Year) State MAY 16 Registrar

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State Registrar 31. Date filed (Month, Day, Year)

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Petek Donmez, M.D. 11119 Rockville Pike #401, Rockville, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Q th Vincent /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 142-14-8202 84 Director April 15, 1924 New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □ Yes 2 No Maryland Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4209 Great Oak Road 20853 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the of Health and Mental Hygiene. Int: If item 27 is marked other than "naturai", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No If Tes, Give Year or Dates: WWII Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Director of Marketing Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Calo Grace Galvin ၉ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are important: If item 27 is any Injury or other trau Therese F. Calo/ Wife 4209 Great Oak Road, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) May 12, 2008 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Sprans M01360 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non Hodgins

Due to (or as a consequence of): Non /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760年 burial-tra Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Cardiac Diregre 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. W*a*s an Malnutrition autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) MD060335 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Philip 327 18111 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2008 Bernard William Carroll May 11, 1:18AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F Yrs. Director October 17, 1941 Washington, D.C. 213-42-9569 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13104-1 Wonderland Way United States 20874 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 δ Specify: 3 Widowed 4 □ Divorced White the Medical ? Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Trave1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Bernard Edwin Carroll Ida May Mastin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship. (Type, Print) Department of Health ar Important: If Item 27 Is any Injury or other trau Patrick Carroll/ Brother 24L Ridge Road, Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate
of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State May , 2008 16, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or or war call ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Carcinoma of Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Coronary Artery Disease physician and s the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2. No 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 XI Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier D052586 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 10 1500 Forest Glen Road, Silver Spring, Maryland 20910 Potel Jayonri, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 16 2008 Registrar

Division of Vital Records, P.O. Box 68760, 冬

ed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 should be fil Department of Heath and Mental I- Important: If item 27 Is marked ott eny linury or other traumatic even once.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street			
l and Healt		Edna Derr Wife 7519 Weatherw			MD 21046 cation - City or Town, State
ges if ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	i		cation - City or Town, State
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permi Depar Impor eny Ir		21. Signature of Funeral Service Licensee 22. Name and Add	-	11824 Reis	sterstown Road
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		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.	ying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
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eath certific attending p for use as 1	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Jeath atte	cial	in the past 12 months? 1 \subseteq Live birth 2 \subseteq Fetal death 3 \subseteq Ectopic pregnant at time of death 5 \subseteq Other (specify)			Month Day Year
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w requires that the de been signed by the should be detached	Completed by			1 ☐ Yes 2 ☐	□ No 3 □ Probably 4 □ Unknown
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 Hours after death. Within 24 Hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	plet			24a. Was an	24b. Were autopsy findings available
The law cete has page 2 s	E O			autopsy performed? 1 Yes 2 No	prior to completion of cause of death? 1 □Yes 2 ☒No
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endi eath. or: A he fu	aţic	2 ☐ Accident investigation M 1	□Yes 2□No		
r Att ter de irect n by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (Street and City or Town, State)	d Number or Rural Route Number,
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Hosp 4 hou Fune tely fi	Medical	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the passes of examination and/or investigation, in my			
thin 2 the mple	Ved	one) and manner stated. 29b. Signature and title of certifier 29c. Lice	nse number	29d Date	e signed (Month, Day, Year)
5 ≥ 5 8	-			29d. Date	
11			57051	10.7	14 13, 2008
IKOj		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		- 24 .20	4 .41 7.24
,	•	WALTER F. ATH1 M. 5755 EDAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature	LANE	(00000)	4 MJ 7:044
Sta Registra		MAY 1 6 2008 32. Registrar's Signature			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 14, Day 2008 Year **Physician** 11:02P M David Robert Ewing /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 12, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F **Funeral** 1950 Washington, D.C. 213-48-0466 57 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Woodbine MD Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21797 7001 Eden Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: 1969-74 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvements Business Owner permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Derr Harry Oliver Ewing ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7001 Eden Mill Road Woodbine, MD 21797 19a, Informant's Name/Relationship (Type, Print) Dorothy F. Ewing/wife Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 05/16/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dancreatic **Physician** Smonths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician death certificate be Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 **X**No 1 □ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 has autopsy certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ို 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6) Other (Specify) NOSPILL this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 | Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AARON J. UHMUS M 6701 N Charles ST TONSON MO Z1204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			For State				land / Dep					1ental F	_	200	00	
	7		Registrar 1. Decedent's Name	Amend 19a e (First, Middle,	.perFh.g8 Last)	/9 5/16/	/08 TT Ce	Timoat	0 0/ 1	Jean		2. Date of	Death	. No.	J [] []	3. Time of Death
£.,	Physici: Medic/		Thomas E	Edward E	lliott							Month May	10 20		Year	3:20 P ^M
	Examin	er	4a. Facility Name (II		give street and n	umber)		4b. City,		Location	of Death				nty of Death	
	Funeral		210 Bridg 5. Social Security N		6. Sex	7. Age (In	yrs. last birthday			If Under		8. Date of	Birth	Harf	9. Birthp	lace (State or Foreign
ь	Director		214 18 205	59	1□ M 2□ F X	94	Yrs.	Months	Days	Hours	Min.	April	Day, Y 11 1		Essex	Co., VA
	pug w		Usual Residence of 10a. State	Decedent 10b, County		10	c. City, Town or l	ocation							1	0d. Inside City Limits
	Maryk f sho ied at	tor	Maryland	Harford			Joppa									1 □Yes 2 No
	n the	irec	10e. Street and Nur	mber				10f. Zip	Code				10g	. Citizen o	of What Cour	ntry?
	th wit	alD	210 Bridge	Drive				21	085					USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed		Armed I	ecedent Ever Forces? s 2 ∑No Give Dates: WW		. Was Dece If Yes, spe 1 ☐ Yes	cify Cuba	ispanic Or an, Mexica Specify	ın, Puerto	èrto Rican, etc.)			lace - Americ lack, White, cify:	
Ö	72 hou natura lical E	ted	(Snec	15. Decedent's	Education grade completed	/ }	16a. Dec	16a. Decedent's Usual Occupation (Give kind of work done during most of working						b. Kind of	Business/In	
Maryland 21215-0036	ithin 7 ne. nan "r e Med	Completed	Elementary/Seco		College	(1-4or 5+)	life.	DO NOT u	se retired	1)	St Of WORK	wig	١,	lal	D	O
2	filed w Hygiel ther ti	S	17. Father's Name (First. Middle. L	N/A	I	Analik	al Care	caker		er's Nam	e (First, Mic				ing Grounds
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ary	shou and M s mar	-	19a. Informant's Na	roe/Relationsh	p (Type. Print)		l l		•						vn, State, Zip	Code)
2	es 1 and 2 of Health if item 27 i		Anna M. W e	ezewski	(c	bughter		Bridge		Jobb						
altimore,	Pages 1 nent of H ant: If ite			☐ Cremation	3 □Removal fro	m State	20b. Place of Disp cemetery, cr	ematory or c	other plac	· i		Date			n - City or To	
≝	permit. Page Department of Important: If any injury of once.		4 □ Donation 21. Signature of Fu	5 ☐ Other (Sp			Holly Hil				/ 14,2		Ba	Ttimo	re,Maryl	Land
Ba	Depri Impe		May	Hor ?	JESSAN			^{22. Name ar} _assahn 7401 Be					പിന	d 212	36	
	NC.		23a. Part1. Enter the shock, or hea	he disease, or o	complications that	t caused the	death. Do not e	nter the moo	de of dyir	ng, such a	s cardiac	or respirato	ry arres	t,	",	Approximate Interval Between
	Physician		Immediate Cause (disease or condition	Final	_a. 110	nsite	in al cet	2020		2010/06/20	Ond	den				Onset and Death
	/Medical Examiner		resulting in death)	1	Due t	o (or as a co	nsequence of):			0						G
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	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, tending to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									econ	e			
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O. Box (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedend in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		e birth 2 in	Fetal death 3	□Ectopic p □ Other (sp		/			_		Date of delive Month	ery Day Year
ري ص	s that ined by	y Ph	Part II. Other signif	ficant condition	s contributing to	death but no	ot resulting in the	underlying o	ause giv	en in Part	I.	23e. [Did toba	cco use c	ontribute to t	he cause of death?
ğ	equire en sig ould b	ed b										1	Yes	2 □ No	3 ☐ Prol	oably 4 □Unknowr
Il Records, P.O.	The law not attempted that the page 2 ships and the page 2 ships and the page 2 ships are attempted to the page 2 ships and the page 2 ships are attempted to the page 2 ships are attempted to the page 2 ships are attempted to the page 2 ships are attempted to the page 2 ships are attempted to the page 3 ships are attempted attempted to the page 3 ships are attempted attempted t	Completed										l a	Vas an autopsy performe es 2	- 1	prior to co death?	psy findings available mpletion of cause of
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ō	Phys er this eral di	٦. ٦	1 Yes 2 2		28a. Da	Inpatient te of Injury	2 ER/Outpati		28c. Injur Wor	4 L N	ursing Ho	ome 5 1 Er			Other (Special curred	fy)
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Division or	or Atte ter dea irecto n by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could ne determin	Zoe. Fla	ce of injury - lding, etc. (S	At home, farm, s	treet, factor	y, office				on (Stre Town,		mber or Rura	al Route Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Medical Cer	29a. Certifier (Check only one)		xaminer: On the	basis of exa	y knowledge, de amination and/or									
	ro the vithin 2	Mec	29b. Signature and	title of certifier	anu ma	anner stated	•	29	c. Licens	e number			290	I. Date sig	ned (Month,	Day, Year)
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	Registr		M	AY 16	2008	Deve	& A	ale								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Pre-H 2879 5/16/08 WS and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5:53 aM **Physician** Rita Carter Ector May 8, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Prince George's County Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🔀 F 414-98-8182 53 MS 02/02/1955 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County works i Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at 1XIYes 2 □ No Cheverly MD Prince George's Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 USA 3017 Cheverly Avenue Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) University of Maryland Cook 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christabell Thomas James A. Carter 2 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3017 Cheverly Avenue, Cheverly, MD 20785 19a. Informant's Name/Relationship (Type. Print) Christabell Johnson / Mother permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tr. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Cemetery 5/18/2008 20a. Method of Disposition Chattanooga, TN 1 XBurial 2 ☐ Cremation 3X Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 21. Signature of Funeral Service Licenses 1501 E. Fort Ave., Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tal Immediate Cause (Final arrhattines deac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month ned by the attent detached for u Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 DOA 1 Yes 2 No Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral I

Registrar

Medical

JACOBS MD 31. Date filed (Month, Day, Year) State

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

5 ☐ Pending

investigation

6 Could not be determined

29b. Signature and title of certifier

and manner stated

28a. Date of Injury (Month, Day Year)

29c. License number D60096

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28d. Describe how injury occurred

32. Registrar's Signature MAY 1 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03667 State of Maryland / Department of Health and Mental Hygiene 2008 Michael Joseph Evans Certificate of Death Reg. No. 1. For State 3. Time of Deat 2. Date of Death Registrar Month Day May 13, 2008 1. Decedent's Name (First, Middle,Last) 1950 hrs Physician/ Evans Michael . Joseph Me वा Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Germantown 13601 Wayne Garden Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country) 5. Social Security Number March 29, 1978 Washington, D.C. Days Hours **Funeral** 30 Yrs Director 216-17-2021 1 X M 2 F 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 1 Yes 2 X No 10a. State Germantown Montgomery Maryland 28a-f show 10g. Citizen of What Country? notified at once, with the Maryland 10f Zip Code 10e. Street and Number United States 20874 19969 Wild Cherry Lane 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral or items? Armed Forces? Married 2 White 1 X Never Married hours after death Yes 2 X No Specify 1 Yes 2 X No specify: f Yes, Give Year 4 Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done event, the Medical Examiner ≥ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Home Depot 72 more, MD 21215-0036 Pages 1 and 2 should be filed within 77 nent of Health and Mental Hygiene. Cashier 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julie Owens David M. Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Be 19a. Informant's Name/Relationship (Type, Print) 19969 Wild Cherry Lane, Germantown, Maryland 20874 item 27 is n r traumatic David M. Evans / Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20, 20a. Method of Disposition May crematory or other place) Baltimore, 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 2008 tment o Donation 5 Other Specify 22 Name and Address of Facility Robert A. Pumphrey Funeral Home / Rockville, Inc. permit. Departm 21. Signature of Funeral Service Licensee 300 West Montgomery Avenue, Rockville, Maryland M01305 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death failure. List only one cause on each line. 'Medical a. Intrapral Gunshot Wound Immediate Cause (Final disease aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ley and transit Physician/Medical **AMENDED** UNPENDED ling physician a 23d. Date of delivery The law requires that the death certificate be 23c. If yes, outcome of pregnancy Box 68760, Year IF FEMALE: Month 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown signed by the atte I be detached for u Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown P.O. à 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of Division of Vital Records. has been si 2 should b autopsy death? nerformed? 2 No ✓ Yes 2 No this certificate page 26.Place of Death (Check only one) 25. Was case referred to medical Nursing Home 5 Residence 6 Other: Scene To the Hospital or Attending Physician: within 24 hours after death. Other₄ Be DDA Hospital: 1 Inpatient 2 ER/Outpatient 3 28d. Describe how injury occurred 1 Yes No 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury Month, Day, Year FOUND: Subject shot self 27. Manner of Death After FOUND: Yes 2 V No Certification: Natura 5 Pending 1950 hrs 28f. Location (Street and Number or Rural Route Number, City May 13, 2008 Director: d in by the Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) 13601 Wayne Garden Drive, Germantown, MD 6 Could not be 3 V Suicide filled in (Specify) Park/Recreation Area determined 24 hours : Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Homicide 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 14, 2008 O.C.M.E.

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

Chross

31. Date filed (Month Aay, Year) 6

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

istrar's Signature

MEURI

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 13, 2008 7:57 A.M **Physician** Vera I. Fuller May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore County Towson Gilchrist Hospice 9. Birthplace (State or Foreign Country) Oxford, England If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ м 2 🗓 F 83 Yrs 1925 12, 050-24-3026 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The World Examiner must be retified a 1 ☐ Yes 2 No Timonium Maryland Baltimore County Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21093 #101 410 Rockfleet Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ZNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ies 1 and 2 should be filed within is of Health and Mental Hygiene.
If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Martins Caterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daisy May George Fletcher ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Timonium, Maryland 21093 410 Rockfleet Road Pages 1 and 2 #101 Sandra Rhoten (Daughter) Injury or other permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evaris Funeral Chapel May 14,08 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Haryland 5 ☐ Other (Specify) 4 Donation Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature o neral Service License 23a. Part Enter the disc as s, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi * C use (fin I disease or condition resulting in death) MONTHS **Physician** MULTIPLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ending physician and use as the burial-trar Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown is been signed by should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HUPERCALLEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an UREMIA autopsy certificate has , page 2 1 ☐ Yes 2 No Vital funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 5 Pending investigation Division 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated 29c. License number 29b. Signature and title of cortifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NCHARLES ST, SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMANIMO 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

2008

1.6

YAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician May 12, 2008 7:45 A M **Dorothy Anne Falker** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard **Ellicott City** 8420 Elko Dr. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Days **Funeral** Months 1□M 💥 F 91 Apr 12, 1917 Director 079-16-0912 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo **Ellicott City** Director Howard MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a or 2. any Injury or other traumatic event, the Medical Examiner must be once. U.S.A. 21043 8420 Elko Dr. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerical **Administrative Assistant** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Fedalis Maurer ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8420 Elko Dr. Ellicott City, MD 21043 Raymond Falker Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1/ Burial 2 □ Cremation 3 □ Removal from State Ellicott City, MD 5-16-08 St. John's Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Se icens Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition da -ARDIO PULMONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): e aus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician a Physician/Medical attending for use as If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year Month Day in the past 12 months? 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>\$</u> pe 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown HYPOTHY ROIDISM Completed 24b. Were autopsy findings available prior to completion of cause of death? USTEO - BROTHRITIS autopsy page 2 s performed DEMENTIA 2 1 No SENILE 1□ Yes 2 No 1 □Yes e Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manper of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier May 12.

Registrar DHMH 17 Rev 1/2001

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MD. 21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8850, CCLUMBIN, 100 HARKWAY

32. Registrar's Signature

31. Date filed (Month, Day, Year)
. MAY 1 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAMAY 13^{pay} 2008 **Physician** 5:22P FEPELSTEIN SYLVIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PIKESVILLE BALTIMORE 56 BARBICAN WAY If Under 1 Year | If Under 24 Hrs. Date of Birth 08/31/1918 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F Months MD 89 Director 215-10-7156 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2√ No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. Iem 27 Is marked other than "natural", or items 23a or 3 56 BARBICAN WAY 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give⁷ Ye ar or Dates: 14. Race - American Indian, Black, White, etc 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PERLOW BERTHA LITVACK DAVID 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILTON FEPELSTEIN/HUSBAND 56 BARBICAN WAY BALTIMORE, MD 21208 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/15/2008 BETH TFILOH CONG. BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatu of Funeral Service Li, ensie 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hrowic 20 yrs ossmud /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): recent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed to the death certificate and by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 **X**No Ö 9 Unknown 9 Unknown σ. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural
2 Accident Injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Acrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 173974 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Goldborg Anno SSIA MY 135 2

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

32. Regi

MAY 1 6 2008

Amend #5, per FD 9887 1/27/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12, 2008 4:55 A.M May Maria Wise Gerwe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1 M XXX 88 Yrs Director 1920 Maryland March 14. 10d. Inside City Limits 10h County 10c. City. Town or Location 10a State show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Machical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson Director 10g. Citizen of What Country?
United States
of America 10f. Zip Code 10e. Street and Number 8424 A Charles Valley Court 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify white Specify: à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental H Louis Herbert Wise Mary Turner Sasscer မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29229 1 and 2 s Health a Bruce Gerwe/ son 410 Bridgecreek Drive Columbia, South Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faith Church
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of ₩ Burial 2 Cremation 3 Removal from State May 15,2008 Mechanicsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A. D.1 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complexitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** 2010 COVS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) as the burial-transi Exami and Due to (or as a consequence of) Box 68760. physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I ed by the a detached for 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 Who this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: thin 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day, Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours fler deal 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tffcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hou To the Funel completely fil Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month,/Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

AALON I CHANKSOND 6701 N-

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Charle St Tawar ND 21204

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 1.0UISE GELWICK 702 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE. BALTIMORE CITY HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 214-24-7625 Nov 16. 1929 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits Maryland N/A Baltimore 1X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Patapsco Street, Apt. 5 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Numerical Registry Social Security Admin. 9 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Turner Myrtle Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19952 Sandra M. Nelson (Daughter) 131 E. Lucky Estate Drive, Harrington, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory, Inc. 5/16/08Baltimore, Maryland 21. Signature of Fundral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EDEMA disease or condition resulting in death) Due to (or as a consequence of): 6 MONTHS STAGE COY END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

The law requires that the death certificate be executed and bunial-tra Division or Vital Records, P.O. Box 68760, physician the as attending use signed by t ate has page 2 s this funeral spital or Attending P nours after death. neral Director: After t y filled in by the funera After Fineral I ospital

Examiner Physician/Medical þ Completed Be ၉

Physician

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Important: If ite
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once,

Physician

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Examiner

Pages 1 and 2 should be filed within 72 hours after of the filed within and Mental Hygiene. The filed filed and Mental Hygiene. Sant: If item 27 Is marked other than "natural", or itel

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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death with the Maryland

Certification:

25. Was case referred to medical examiner?

29a. Certifier

(Check only one)

29b. Signature and title of certifie

5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES COI

29c. License number

29d. Date signed (Month, Day, Year) 11 2008

BALTIMORE, MID

30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) SOUTH HANOVER STREET MICHELLE ORMAN 3001

31. Date filed (Month, Day, Year)

2008



DHMH 17 Rev 1/2001

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryland / E	Department of Health and Certificate of Death	Mental Hygiene Reg. No.	2008 15977
Physic /Med		1. Decedent's Name (First, Middle, Last) Sara J. Gaeta		2. Date of Death Month Day 05/13/2008	Year 3. Time of Death
Exami		4a. Facility Name (If not institution, give street and number) Holly Hill Nursing	4b. City, Town, or Location of Dea Towson If Under 1 Year If Under 24 Hr.	Ba	County of Death I timore 9. Birthplace (State or Foreign
Funera Director	•	5. Social Security Number 087–09–2690 Usual Residence of Decedent 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last bir	Yrs. Months Days Hours Mir		New York
Maryland r-f show fied at	tor	10a. State			10d. Inside City Limits 1
th with the 23a or 28a Ist be noti	al Director	10e. Street and Number 4308 Arizona Avenue	10f. Zip Code 21206	U.S.	
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	rto Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ad within 72 hours aff giene. er than "natural", or ; the Medical Exami	Completed b		Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking	nd of Business/Industry
N pob t	æ	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maiden S	Name (Surname)
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	2	, , ,	Rosalia D. Mailing Address (Street and Number or 1) 308 Arizona Avenue, Balt	Rural Route Number, City or	Town, State, Zip Code)
Baltimore, M sermit. Pages 1 and 2 Department of Health mportant: if Item 27 I my Injury or other tra		20a. Method of Disposition 1 □ Burial 2 🗶 Cremation 3 □ Removal from State	f Disposition (Name of ery, crematory or other place)	Date 20c. Loc	cation - City or Town, State
Baltimor permit. Pages Department of Important: If II any Injury or of		21. Signature of Funeral Service Licensee Olganization Solicia		Leonard J. Ruck,	Inc.
Physiciar /Medica		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as card		Approximate Interval Between Onset and Death
68 / 60, C. ifficate be executed by g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate bases. Extra Underfining Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence)	of):		
Goath certificate e attending phys d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)	2	23d. Date of delivery Month Day Year
_ <u> </u>	þ	Le vier significant continuous continuous to death out not resonance	in the underlying cause given in Part I.		se contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐Unknown
The la	Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
on or Vital F ding Physician: Th h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. 28b.	Othor	eath Check onl one Home 5 Residence 6 28d. Describe how injur	
DIVISION al or Attending s after death. al Director: Afte	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, find building, etc. (Specify)	arm, street, factory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the control one one of the certifying Physician: To the best of my knowledge of the certifier one of the certi	nd/or investigation, in my opinion, death o	ocurred at the time, date and	d place, and due to the cause(s)
Mitter Conf	Σ) who we	29c. License number	04 5	te signed (Month, Day, Year)
10		30. Name and address of person who completed cause of death (Item 23a) 7407 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	(Type, Print)	L, Towsor	1 MD Z1204.
S Regis	tate strar		hall		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edward L. Hildebrand, Jr. May 15, 2008 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 412 Rogers Ave. Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Oct. 7, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F 79 1928 Director Ohio 298-20-7788 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2 TyNo Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 21060 412 Rogers Ave. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Confi Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 1x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ò Korean Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Physical Measurement Tech. Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward L. Hildebrand, Sr. Mary Lou Crawford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s i Health a Mary Edith Hildebrand / Wife 412 Rogers Ave., Glen Burnie, Maryland 21061 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 permit. Pages Department of Important: If It any injury or or May 19, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Mount View Cemetery 4 Donation Marriottsville, Maryland Name and Address of Facility irkley-Ruddick 21 Crain Hwy., 21. Sign ce Licans e Funeral Home, P.A. S.E., Glen Burnie, Maryland 21061 00 of dying, such as carolac or respiratory arrest, 23a, Part 1 onter the disease, or complications that caused the death. Do not enter the me shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed Exami and attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 2 🗆 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 □Yes 2 🙀 No 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 5 Pending 1 X Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hin 24 hours after deatl the Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide filled Hospital 🔯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number May 16, 2008

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Stuart Bell, M.D., 200 E. 33rd Street, Suite 650, Baltimore, Maryland 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

			State of Maryland / Dep			ne.			
			FOL	rtificate of Death	Reg. No.	8 15979			
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death			
	Physicia /Medic		Betty Jane Helwig		May 13, 2008	10:30 A M			
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of				
	4 1	Sit .	Genesis Healthcare Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Brooklyn Park II Under 1 Year If Under 24 Hrs.	8. Date of Birth	1timore			
2.4	Funeral Director		216-30-2267 1 M 2 X F 72 Yrs.	Months Days Hours Min.	(Month, Day, Year) 06-18-1935	Birthplace (State or Foreign Country) Maryland			
	D D		Usual Residence of Decedent		00 20 2000				
	arylar show	7	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	the M	Director	MD Baltimore	Arbutus 10f. Zip Code	10g Citizen of W	g. Citizen of What Country?			
	3a or	D	1563 Lister Road	21227		United States			
	death	Funerai		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race	- American Indian, , White, etc.			
9	or ite	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2x No Specify:	Specify:				
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28e-f show he Medical Examinar nuat be notified at	d by	3.A. Widowed 4 Divorced Year or Dates:	edent's Usual Decupation	16b. Kind of Bu	White			
Ϋ́	in 72 n "nai	Completed	(Specify only highest grade completed) (Give	a kind of work done during most of work DO NOT use retired)	ing	sinessindustry			
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Disabilities Assist	tant Bus C	ompany			
פ	al Hygie d other	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Sumame	a)			
yla	should be ind Mental I marked o umatic eve	70	John Coates Peddicord		ane Hopkins				
Mar	12 sho h and 7 is m trauma	1		ing Address (Street and Number or Run		manufacture and the second second			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Maniel Hygiens. Important: if fem 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinar numbers notified at once.		Thomas Helwig - son 3599 20a. Method of Disposition 20b. Place of Disp	osition (Name of practory or other place)	Date 20c. Location - 0	Land 21074 City or Town, State			
E E	Pages nent of I int: If It		123 Burial 2 Cremation 3 Hemoval from State	i raci	7 7, 2008 Elkri	dge, Maryland			
Baltimore,	permit. I Departm Importa any Inju					Funeral Home at			
<u>~</u>	Departiment of the policy of t			1P, Inc., 7250 Wash					
S			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	« /Y		Approximate Interval Between			
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	/Medical Examiner		Due to (or as a consequence of):	,					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
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P. O.	that the de led by the a detached f	hys	9 Unknown 9U Unknown						
Ś	es the	by F	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contr				
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סר	neral	n: T	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how injury occurre				
<u>0</u>	eath. or: Af	catic	2 Accident investigation	M 1 Yes 2 No					
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,			
ш	spital ours a neral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the cause(s) and ma	nner as stated.			
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after dash. To the Funeral Director: After this certificate has been signed by the attending phy To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date and place, a	and due to the cause(s)			
	To the within To the comp	Ň	29b. Signature and title of pertition	29c. License number	29d. Date signed	(Month, Day, Year)			
•	4		· Mak Dem ~	1070555	May 1	4,2008			
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	a. Acli	1. 2/230			
· H	° Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signature	12451 JON 1710	ma, Jarres	,100 -101			
	Registr		30. Name and address of person who completed cause of death (Item 23a) (Type 13a). Date filed (Month, Day, Year) 29b. Signature and title of pertition. 30. Name and address of person who completed cause of death (Item 23a) (Type 13a). Denns My 13a (Type 13a). Denns My	ALA S					

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	-	5. Social Security Number	6. Sex		yrs. last birthd		- 11	ler 24 Hrs.	8. Date of B	Inth		Birthpla	ce (State o	r Foreiai
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		Usual Residence of Decedent							08-20	1795		ryla		
	.	10a. State 10b. County	1	10c.	. City, Town or	Location						100	I. Inside Cit 1 ☑Yes	-
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	<u>e</u>	15. Deceder	nt's Education	/\	16a. De	cedent's Usual	l Occupation	anat of words		16b. Kind	of Busine	ess/Indu	stry	
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ć	Completed	6	0		Manu	facturi	3			Venet		Bli	nds	
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	<u> </u>	Frank Zak						ud Joh						
		19a. Informant's Name/Relations	ship (Type. Print)		19b. M	ailing Address ((Street and Nur	mber or Rui	al Route Num	ber, City or 7	Town, Stat	te, Zip C	code)	
		Tisa Hartman	(Daught			East F	offman		t Balt	imore				
	Щ	20a. Method of Disposition 1 → Burial 2 □ Cremation	3 □Removal fro	om State	cemetery, o	crematory or oti	her place)	1						
	1	4 Donation 5 DOther (l F	Holly H	ill Cem	netery d Address of Fa		5-2008					
		21. Signature of Funeral Service	Licensee			ZZ. Name and		ICRIUV I II I A			()	111111111	TTK T	11C .
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Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAY 1 6 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Hogan 05 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Gardens Nursing Center N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 3, 1950 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 222-34-4370 58 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at Maryland Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 3440 6th Street Apt. 2 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Sec College (1-4or 5+) econdary (0-12) Construction Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Calvin Hogan Mary Belle Burris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sadie Parosky/Sister 1830 Congressional Village #3204 Middletown Delaware 19709 20b. Place of Disposition (Name of cemetery, crematory or other place Hilltop Service Corp. Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/17/08 Towson Maryland 22. Name end Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licenses Kristina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) be detached ☐ Yes 2☐ No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an has autopsy perform 20 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No J₀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 Natural 1 Tes 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2008

07:50a

9. Birthplace (State or Foreign

North Carolina

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

on Woods Road. MD 21234

Year

1 ☐ Yes 2 No

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 16

DHMH 17 Rev 1/2001

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Julia Ellen Hess May 10, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Summit Park Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Fe b • 24, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1916 North Carolina 1 □ M 2 🔀 F 92 Director 244-05-4772 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10a. State 10b. County 10c. City. Town or Location Director Marv1and Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 925 Prestwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify. þ Specify: 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Ida P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Hess Lund (Daughter) 59 English Run Circle, Sparks, MD. 21152 20b. Place of Disposition (Name of Baffilmore Crematory of Loudon Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/08 Baltimore, Maryland 21. Signature of Funeral Service Liceose 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Divone /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 □ Yes 2 No Month 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Completed by Be

Medical Certification: To

29a, Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

				1 □ Yes 2 E	∃No 3 Probably 4 Unknow			
				24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause o death? 1 ☐Yes 2 ☐No			
25. Was case referred to medical			26. Place of Dea	ath (Check only one)				
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 [lome 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred			
3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M21228

3. Time of Death

10d. Inside City Limits 1 ☐Yes 2 ☑ No

Approximate Interval Between Onset and Death

Day

8:25 a M

AVCE 31. Date filed (Month, Day,

> 2008 6

State Registrar

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			For State Registrar		State of M	aryland		partment <i>ertificate</i>			lental H	ygiene Reg. No	200	8 598;
ja.	Physicia	_	1. Decedent's Name (Firs	st, Middle, Las	t)		На	Mmer	^		2. Date of D	Peath Da	Year 200	3. Time of Death
	/Medic Examin	101	4a. Facility Name (If not is	Institution, give	street and number)		10-1			Location of Death	1	4c	. County of Dea	th
	Funeral Director	A	301 Bryanst 5. Social Security Number 215-34-9113	er 6. Se		e (In yrs. Ia	<i>st birthd</i> Yrs	ay) If Under 1		stown If Under 24 Hrs. Hours Min.	8. Date of E (Month, E Feb 19	Day, Year)	9. Biri	imore thplace (State or Foreign ountry) ryland
200	ow tt		Usual Residence of Dece 10a. State 10b.	. County		10c. City,	Town or	Location						10d. Inside City Limits
Many	Mary Fied a	tor	MD	Baltim	ore	Reisterstown								1 ☐ Yes 2 🗓 No
th th	or 28s	Director	10e. Street and Number			10f. Zip Code						10g. Cit	tizen of What Co	puntry?
4	23a ust b	ral	301 Brya	anstone		21136						<u> </u>	U.S	
0	items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2	2⊠ Marriad	12. Was Decedent Armed Forces?	s? If Yes, specify Cuban, Mexican, Puèrto Rica					ecify Yes or No Rican, etc.)	10-	14. Race - Ame Black, Whit	
9500-	al", or	þ	3 ☐ Widowed 4 ☐ [1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			1 ☐ Yes 2	No.	Specify:			Specify:	White
5 8	should be the whith 7 z hours aret bean with the maryaring anounce mental Hygiene; marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	15. [/Specify on	Decedent's Ed	ucation de completed)		(G	cedent's Usual	k done d	during most of work	cina	16b. K	(ind of Business	
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ע ק	Hygiel ther ther the		12 17, Father's Name (<i>First</i> ,	Middle, Last)		Housewife 18. Mother's Name (First,					e (First, Midd	le. Maider	Own He	ome
משמש	ed of ced of c eve	To Be	John Ch		Otter					Hele		bold	, 62	
מולא מולא	shour tnd M s marl umati	F	19a. Informant's Name/F				19b. M	ailing Address	(Street a	and Number or Ru			or Town, State, .	Zip Code)
, INE	arth a		Louis Hamme	er	Husban			Bryans			Reister	stow	n, MD	21136
ore,	of He		20a. Method of Disposition		Removal from State	20b. Pla	ace of Di metery,	sposition (Name crematory or of	e of her plac	re)	Date	20c. L	ocation - City or	Town, State
Dallimor	tment tant: ijury		4 ☐Donation 5 ☐	Other (Specify)	Dul	aney	Valley					monium,	
ם ספו	pennit. Fages I and a Should be lited within 7.2 hours after beart with the warytan beartment of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral	Service Licen	see /	6				ss of Facility 1				
-			23a Part1. Enter the dis	sease, or comp	olications that caused	d the death.							wii, FID	Approximate
P	hysician		Immediate Cause (Final disease or condition		one cause on each li	ne. <i>0.1.000</i>								Interval Between Onset and Death
	/Medical	1	resulting in death)		a. Due to (or as	a conseque	ence of):	07 (<u>, </u>	nary	NIAC	iae,	<i>y</i>	
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S	an and		resulting in death) Last	- 1	Due to (or as	a conseque	ence of):							
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Š į	ding p	Physician/Medica	IF FEMALE:		23c. If yes, outcome	of pregnar	ncv						23d. Date of de	livon
XOO HELD	atten	cian	in the past 12 mont	ths?	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death	3 ☐ Ectopic pre 5 ☐ Other (spe		,		.	Month	Day Year
	by the	hysi	9 ☐ Unknown		9 Unknown									
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	all: 1	Be Co	25. Was case referred to	o medical					-	26. Place of Dea	1□ Yes th <i>(Check</i> o <i>nl</i> e		o 1 🗆 Yes	s 2□No
> 2	his ce	면 면	examiner?		Hospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpa	tient 3 □ DO/	A Othe	er: 4□ Nursing H	ome 5 Re	sidence	6 □Other (Spe	ecify)
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DIVISION OF VICE	within 24 hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s	Medical (ysician: To the best niner: On the basis of and manner st	of examinati								
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	10		30. Name and address o	of person who	completed cause of d	leath (Item	23a) (Ty	pe, Print)	200	d floor	Ba	Itim	ore K	008 1D21244
	Sta Registr		31. Date filed (Month, Da	ay, Year) 1 6 20		rar's Signat	ure	barke		,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** Hanes mma /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cherry BALTIMOR Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday If Under 24 Hrs Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 ■ M 2 🖟 F 214-03-187 Director Marylano Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Mr Baldwin Director TIMOR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 2 White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be mma Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 6724 M()nerro 20a. Method of Disposition
1 Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State DALTIMORE, MD 4 Donation 5 Other (Specify) 108 22. Name and Address of Facility ford Rd. CALTIMORE MIS 21234 21. Signature of Funeral Service Ligensee Tuneral complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Physician lmonu /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

7

LISW. MORPHA

37 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAV. D

MAY 1 6 2008

31. Date filed (Month, Day, Year)

D3229

Relair mp

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

T - State Registrar Certificate of Dead 1. Decedent's Name (First, Middle, Last) JULIA JORDAN 4a. Facility Name (If not institution, give street and number) FUTURECARE LOCHEARN BALTIMO		Reg. No.	3								
Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) FUTURECARE LOCHEARN BALTIMO		2. Date of Death 3. Time of Death									
/Medical JULIA JORDAN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local FUTURECARE LOCHEARN BALTIMO	IVIOTILIT	ath Day Year	3. Timle of Death								
FUTURECARE LOCHEARN BALTIMO	MAY	12 2008	12:30 p ^M								
	cation of Death	4c. County of Dea	th								
5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If U		BALTIM									
Funeral 1 M 2XXF Months Days Ho	lours Min. (Month, Da	y, Year) Co	thplace (State or Foreign ountry)								
Director 251-48-6133 79 Yrs. Usual Residence of Decedent	SEPT	L4 1928 SO	UTH CAROLINA								
			10d. Inside City Limits								
MARYLAND N/A BALTIMORE			1 X Yes 2 □ No								
MARYLAND N/A BALTIMORE 10e. Street and Number 10e. Street and Number		10g. Citizen of What C	ountry?								
To a control of the c	21215										
3901 W ROGERS AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, Me	3901 W ROGERS AVENUE 21215 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wh										
Armed Forces? If Yes, specify Cuban, Me 1 Never Married 2 Married 1 Yes 2 XNo 1 Yes 2 XNo 1 Yes 2 XNo 1 Yes 2 XNo		Black, Whi									
2 3 Ma 3 Ma Widowed 4 Divorced Year or Dates:		Specify: BL.									
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	n ng most of working	16b. Kind of Business	/Industry								
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 12th grade NURSE		HEAL	mu								
To a. State 10b. County 10c. City, Town or Location	. Mother's Name (First, Middle	l	111								
17. Father's Name (First, Middle, Last)											
The property of the property o	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,										
Donnie M. Del-Rio/Niece 3901 W. Rogers											
Donnie M. Del-Rio/Niece 3901 W. Rogers 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or									
1Xi Burial 2 □ Cremation 3 □ Removal from State 1Xi Burial 2 □ Cremation 3 □ Removal from State 4 □ Donatjon 5 □ Other (Specify) WOODLAWN CEMETERY	05-17-08	MOODT AMN	MADVIAND								
	f Facility	WOODLAWN,									
21. Signature of Funeral Service Licensee 22. Name and Address of WILLIAM C BE 1206 W NORTH	ROWN COMMUNITY H AVENUE	Y FUNERAL H	OME P.A.								
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sur shock, or heart failure. List only one cause on each line.	uch as cardiac or respiratory a	rrest,	Approximate Interval Between								
Physician Immediate Cause (Final disease or condition a Cohdioc dlhost	•		Onset and Death								
/Medical resulting in death) Due to (or as a consequence of):											
Examiner Sequentially list conditions. b. Sequentially list conditions.											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
al E											
d											
IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant		23d. Date of de	elivery								
The state of the		Month	Day Year								
and the state of											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	10	tobacco use contribute									
Celebrorasculae Accident, DJ Dementia, Hypertension	120,	Yes 2 No 3 F	Probably 4 Unknown								
à an almentia, hyperlension	24a. Was	psy prior to	autopsy findings available completion of cause of								
Con Con	peri 1□ Yes	ormed? death? 2₽No 1 ☐ Ye									
25. Was case referred to medical examiner? Hospital: Hospital: 4 Description of DER/Outpetient and Dea	6. Place of Death (Check only										
1 Yes 2 No No No No No No No	4 Nursing Home 5 Res	idence 6 Other (Sp how injury occurred	ecify)								
25. Was case referred to medical examiner? 1	2 □ No	now injury occurred									
2 Accident investigation 3 Suicide 6 Could not be determined	28f. Location	Street and Number or F	Rural Route Number,								
27. Marther of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 4 Homicide 2 Accident 5 Pending investigation 6 Could not be determined 2 Accident 3 Suicide 4 Homicide 4 Homicide 2 Accident 5 Pending investigation 6 Could not be determined 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 2 Accident 5 Pending investigation 6 Could not be determined 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Pending investigation 6 Could not be determined Could not be determined Could not be determined Could not be determined	City or To	wn, State)									
2 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0											
one) and manner stated.											
29c. License nun		29d. Date signed (Mor									
11100	775	05-13	-2008								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Young Dangle State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	St Rollin	1010 M	221201								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 3 **Physician** 40 James Henry Johnson Jr. /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number **Examiner** mary pand General Raltinore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**™**M 2□F 219-26-9773 69 Director 02/09/1939 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Balt.imore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2713 W. North Ave. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner and. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th College (1-4or 5+) Inspector Crown Port 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James H. Johnson Sr. Addie Richards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecil Johnson/Wife 2713 W. North Ave. Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 05/19/08 Baltimore, 22. Name and Address of Facility Wylie Funeral Home P.A. Woodlawn Cemetery 21. Signature of Funeral Service License 638 N. Gilmor St. Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emorrha ubarachnoia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VER Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed was to the cause). Examiner The law requires that the death certificate be executed ia he tes attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe After this certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: After the funeral by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State

29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 2008 4:22 P JUE X May 15, /Medical ONG 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chesapeake Hospice House Linthicum Anne Arundel if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. **Director** 219-94-7285 95 15, 1912 China Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2X No Directo Maryland | Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be r than "natural", or items 23a the Medical Examiner must b 463 Aventura Ct. Funeral 21061 United States Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: ğ 3 X Widowed 4 ☐ Divorced Asian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home nt of Health and Mental Hyg If item 27 is marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ (unknown) (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Chan / Granddaughter 463 Aventura Ct., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 20, 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 2008 Woodlawn, Maryland ure of Funeral Service Licensee 21. Signs 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. OV 421 Crain Hwy. SE Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Der tens con /Medical r as a consequence of): Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by the period of the period of the signal of the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 Unknown Be Completed certificate has b rector, page 2 sl Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,-after death.

| Director: / 124 hours after le Funeral Dire pletely filled in b within 24 hou To the Fune completely fi

				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						
25. Was case referred to medical		26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐ [ome 5□ Residence 6 ☑Other (Specify) Hospice								
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury							
3 ☐ Suicide 6 ☐ Could no determin		nome, farm, street, factorify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,						
	Physician: To the best of my kn										

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

MAY 15 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 2000 11.45 PM Bernard Jr. Koontz 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Washington Medical Center Glen Hone 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**☑**M 2□F 212-76-4606 49 Director May 30 1958 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 7706 Suitt Drive 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after eath and Mental Hygiene.
n 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Be Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Constructor & Installer Sign Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ W. Koontz Sr. Eileen Watts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Eileen Koontz (mother) 7702 Suitt Drive, Pasadena, MD 21122 if of Heal! Date 19 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' May 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. 2008 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Fune V Service Lice/see 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli atio's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Immediate Cause (Final letastat avcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 27. Manufer of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

5

DHMH 17 Rev 1/2001

Dontz

State Registrar

31. Date filed (Month, Day, Year)

J20 592



M

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** May 14, 2008 11:55A M Lillian Pruitt Leach /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Valley Nursing & Wellness Rockville Birthplace (State or Foreign Country) Il Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🗓 F May 25, 1918 Maryland Director 89 218-24-0485 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. ?? Is marked other than "naturel", or itema 23a or 28a-1 show traumatic event, the Moulcal Examinar must be notified at 1 ☐ Yes 2 X No <u>Rockville</u> Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20852 11201 Buckwood Lane by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No tf Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Real Estate Agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Ward Horace Pruitt 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 411 Winter Walk Drive Gaithersburg, MD 20878 Item 27 i Jackie Hall/POA/Executrix 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite eny injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/15/08 Beltsville, MD Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service MD 21029 MO1251Beverly L. Heckrotte, P.A. Clarksville, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SYNCE **Physician** tow hrs /Medical Due to (or as a consequence of): bullation **Examiner** < Ca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medicai tF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Severe Dementi 3 Probably 4 Unknown 1 Tes 2 No Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performed? 1 ☐ Yes 2 💆 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 330 ROC Research BLUD MENDHIRAT 2401 32 Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar 6 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of Health Certificate of Death	
	Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year 3. Time of Death
1	/Medic	al	Louise D. La Rouche	May 15 2008 3 45 H.M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Baltim	on of Death ORE Ac. County of Death Bulliynere
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea	ler 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	9/12/23 Dwilyn, VA
	yland now		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-fsk	Director	MD Baltimore Baltimore	1 □ Yes 2 ☑ No
	vith th			10g. Citizen of What Country?
	ns 23a	Funeral	11. Marital Status 12. Was Decedent Ever In U.S. 13. Was Decedent of Hispanic	Origin? (Specify Yes or No- 14. Race - American Indian,
9	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaminar must be notified at			4.
21215-0036	hours ural",	d by	3 Midowed 4 □ Divorced Year or Dates:	White
15-	in 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during mile. DO NOT use retired)	16b. Kind of Business/Industry
212	filed withii Hygiene. ther than	Com	Elementary/Secondary (0-12) College (1-4or 5+)	at home
put	uld be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last)	ther's Name (First, Middle, Maiden Surname)
Maryland	2 should and Mer Is marke raumatic	ျှ		mber or Rural Route Number, City or To n, State, Zip Code)
	- R N -		Condu BATHORY 327/10 TREE	= Ct BACTIMORE MD 21221
altimore,	S = = 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
ţi	Parie I		4 Donation 5 Other (Specify)	& 5/17/08 Elkadge MD
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	TOO HARFORD PLA, DALTIMORE, MOZIES
	_		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such	as cardiac or respiratory arrest, Approximate
	Physician		shock, or he if failure. I st only one gause on each line. Immediate Cause (Finu) disease or condition	Interval Between Onset and Death
J	/Medical Examiner		resulting in death) a. Due to (or as a construence of):	
	Examiner	i.	Sequentially list conditions, if any, leading to immediate cause. Enter underlying b. Due to (or as a consequence of):	
W	uted d ansit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events c.	
0,0	e exec ian an urìal-tr	i Exa	resulting in death) Last Due to (or as a consequence of):	
68760,	rificate be executed by physician and as the burial-transit	edical	d	
			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
Box	that the death cered by the attendir detached for use	Physician/N	in the past 12 gronths? 1	Month Day Year
P.0	at the d by th etache	Phys	9 Unknown	
ds,	requires that the death ce been signed by the attendir hould be detached for use	þ	Part in Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	te law requires t has been signe ge 2 should be c	Completed		24a. Was an 24b. Were autopsy findings available
Re	The law cate has b page 2 sl	omp		autopsy prior to completion of cause of performed? death?
ita		BeC	OF 147	1 □ Yes 2 No 1 □ Yes 2 □ No ace of Death <i>(Check only one)</i>
of V	ys Si is		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	Nursing Home 5 Residence 6 ☐ Other (Specify)
ono	ding I h. After funer	tion	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2	28d. Describe how injury occurred
Division of	Attending or death. ector: Afte by the fune	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
Ö	ital or rs afte ral Dir led in	Cert	4 ☐ Homicide building, etc. (Specify)	City or Town, State)
	Hospital 24 hours a Funeral I tely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date of examiner: On the basis of examination and/or investigation, in my opinion, or and manner stated.	and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	er 29d. Date signed (Month, Day, Year)
	F > F 0		Vela C Colate July MB 0243	156 May 16. 200 f
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 1100 11 - 221200
	8		31. Date filed (Month, Day, Year) 3. Date filed (Month, Day, Year) 2. Registrar's Signature	He. MOU Dathwarem PONDS!
	Sta Registr		MAY 1 6 2008 And the state of t	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:15 P M May 6, 2008 Milton Lanius, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Nursing Home Baltimore Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) December 6, 1922 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 € M 2 □ F Director Maryland 219-03-4523 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show notified at 1 ☐ Yes 2√√ No Director Maryland Anne Arundel Severna Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code o e ms 23a (must b 6 Anne Court 21146 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If ¥es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2√√ No Specify. Specify: 3 Widowed 4 □ Divorced White permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Relations Verizon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ဂ Mary Virginia Gilbert Walter Milton Lanius, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Jensen- daughter 6 Anne Court, Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery May 10, 2008 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility M0123 Fleck Funeral Home, INC. 7601 Sandy Spring Rd., Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): physician Division or Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ 1 ☐ A Month Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown After this certificate has been signed by it ineral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 JUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 □ N death? 1 □ Yes 2 200 2 No Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) D61785 12

State Registrar 31. Date filed (Month, Day, Year)

MAY 15 2008

8800 Walther Blud Parville, MDZ1234

of person who completed cause of death (Item 23a) (Type, Print)

34. Registrar's Signature

MO

	1	For State Registrar	State	of Maryla		artment of <i>rtificate c</i>			•	giene Reg. No	1100	15992
Physician	1	. Decedent's Name (First, Midd	,						2. Date of De Month	ath Da 9	ay Year 2008	3. Time of Death 4:15 A M
/Medical Examiner	4	Maria C. a. Facility Name (If not instituti	-	umber)		4b. City, Towr	, or Location		May		. County of Deat	
Examiner	ľ	Bethesda Hea				Bethes				Me	ontgomer	У
Funeral Director		Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yr. 82	s. last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da Sept. 2.	th ay, Year, 5, 19		hplace (State or Foreign untry)
	Ĺ	sual Residence of Decedent										
arylar show	1	0a. State 10b. Count	,		City, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 No
ith the Ma or 28a-f s be notified	L		gomery	D	ethesda	10f. Zip Cod				10a C	itizen of What Co	
with t		0e. Street and Number	Tama Dan	0 m 0 m 1 T	7.3 ~	20814					ted Stat	
fter death v	\vdash	5721 Grosvenor		cedent Ever in		Was Decedent of Yes, specify C		rigin? (Spec			14. Race - Ame	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		1 ☐ Never Married 2 ☐ Ma 3 🕅 Widowed 4 ☐ Divorce	If Yes G	2 No Sive		fYes, specify C 11X2Yes 2□1					Black, White	e, etc. L ite
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Eventione. To Be Completed by F	-	(Specify only high	nt's Education est grade completed		i (Give	dent's Usual Oc kind of work do DO NOT use re	ne durina mo:	st of working	g	16b. F	Kind of Business/	Industry
withi jiene. r thar		Elementary/Secondary (0-12)	College	(1-4or 5+)	Homen		,			Own	Home	
tal Hyg d other event, Be C	1	7. Father's Name (First, Middle	, Last)				18. Moth	er's Name	(First, Middle			
Menta	L	Rosendo Cadena Maria Gor. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rot								Z		
2 sho and l		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town										,
and lealth m 27 her tr	1	Alan A. H. Lop	ez / Son	001				N.W.			con, D.C	
Pages 1 ment of h ant: If ite	2	0a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (- 04-4-	cemetery, crer lice Ce	•	olace) ¦	May 1 2008	6,	Alic	e, Texas	5
permit Depart Import any Inj once.	2	1. Signature of Funeral Service	e Licensee		01360 Ma	Name and Adckville, ckville, ryland 2	dress of Facil Inc 300 0850–280	ity Rober 0 West 1 05	rt A. Pun Montgome	phre ry Av	y Funerall Venue, Roc	Home/ kville,
Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Li mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying Lause (Disease or injury	a Due to	each line. Failure o (or as a conse	to Threquence of):	ive	dying, such a	s cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	t	Cause (Disease or injury) hat initiated events esulting in death) Last	c	o (or as a conse	equence of):							
nat the death certified by the attending etached for use as Physician/Me		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of preg birth 2 Fe gnant at time o	tal death 3	Ectopic pregn Other (specify					23d. Date of del Month	ivery Day Year
or Attending Physician: The law requires that after death. Director: After this certificate has been signed the in by the funeral director, page 2 should be deterent from the funeral director. To Be Completed by Pleartification: To Be Completed by Pleartification: To Be Completed by Pleartification.	F	art II. Other significant condi	tions contributing to	death but not re	esulting in the u	nderlying cause	given in Part	1.	23e. Did 1	tobacco	use contribute to	the cause of death?
been signature should b	-								1 🗆	Yes 2	2 ∑ No 3□ Pr	robably 4 🗆 Unknown
: The law requir cate has been s page 2 should	-								24a. Was auto perfo 1 🗆 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of 2 □No
certificate rector, pag	2	5. Was case referred to medic examiner?							(Check only o			
this ral dir		1 ☐ Yes 2 🏋 No 7. Manner of Death		Inpatient 2	☐ ER/Outpatier 28b. Time o	IL SEL DOA			ne 5 🗌 Resi 8d. Describe		6 ☐ Other (Spe	cify)
Attending Physician: r death. ector: After this certificity the funeral director, by the funeral control of ification: To Be C		1 X Natural 5 ☐ Pend		nth, Day, Year)	Injury		njuryat Vork? I∐Yes 2□		ou. Describe	now my	ary occurred	
tal or Attending Phys rs after death. ral Director: After this led in by the funeral dir Certification: To		3 Suicide 6 Coul	not be 28e. Plac	ce of Injury - At ding, etc. (Spe		eet, factory, offi	ce	2	8f. Location (City or To			ural Route Number,
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu Medical Certification	4		ing Physician: To the and ma									
To the within To the comp.	*	29b. Signature and title of certif	1	ow , a	MD		ense number				ate signed (Mont	
5		O. Name and address of person					201. R	Rockvi	11e. M	[arv]	land 208	50

DHMH 17 Rev 1/2001

State ^{*} Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year Month May 15, Timothy Adam 12:40P M McAuliffe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4 Blue Silo Court Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2 □ F Oct 27, 1972 Washington, D.C. 212-06-1373 35 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits 1X Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 USA 4 Blue Silo Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√∑ No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Technology <u>Salesperson</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Adam McAuliffe, Jr. Mary Rowland Gale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary G. McAuliffe/mother 4 Blue Silo Ct. Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 05/16/08 Chesapeake Crematory Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 18 months Colon Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d, Date of delivery 3 ☐Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

Be

Funeral

Director

ns 23a or 28a-f show must be notified at

death 1

be filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and once.

altimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must b

burial-transit and Box 68760, physician the attending p P.O. signed by the a Division or Vital Records, director, this funeral

l or Attend after death Director:

24 within 2.

Hospital hours a Funeral filled in by the

Physician/Medical

≥

Completed

Be

Certification:

Medical

25. Was case referred to medical examiner?

1 Tes

27. Manner of Death

1X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

2X No

5 Pending investigation

6 Could not be determined

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

1∐ Yes 2X No 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and

28a. Date of Injury (Month, Day Year)

29c. License number D61083

29d. Date signed (Month, Day, Year) May 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 Medical Center Dr. #300 Rockville, MD 20850 Thambi, M.D.

1 Inpatient 2 ER/Outpatient 3 DOA

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

31. Date filed (Month, Day, Year) MAY 1 6 2008 State

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

MAY 16

ORIGINAL

			State of Maryland / Depa	artment of Health and N	lental Hygie	ene	
			. Iogione	rtificate of Death	Reg	. No. [] []	: 599
П	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
-de	/Medic		Grace Mary Marshall		May 1	1 2008	7:40 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
A.	Europal	-	Tate Hospice House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Linthicum If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Anne Aru	
	Funeral Director		219-18-7396 1□M 2NF 82 Yrs.	Months Days Hours Min.	(Month, Day, Y		place (State or Foreign intry) vland
	р .		Usual Residence of Decedent		John J.	1720 Har)	
	arylar show	ř	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2 ▼No
	Ba-f	Directo	Maryland Anne Arundel Jessup				
	a or		10e. Street and Number 2053 Horseshoe Circle	10f. Zip Code 20794	109	i. Citizen of What Cou USA	intry?
	filed within 72 hours after death with the Maryland Hygiene Hyan". Instural", or items 23a or 28a-f show with the Macies Evanning must be notified at	Funeral			ecify Yes or No-	14. Race - Amer	ican Indian.
တ	r iter	Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	etc.
ğ	ral", o	by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □Yes 2 【No Specify:		Specify:	White
2-	72 h	Completed	(Specify only highest grade completed) I (Give	dent's Usual Occupation kind of work done during most of work	ing 16	b. Kind of Business/Ir	ndustry
121	vithin ane. than'	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) ol Attendant		Anne Arund	
2	filed v Hygie ther t	Co	8 () SCHO		e (First, Middle, Ma	Government iden Surname)	
an	d be ental ked o	To Be	Bernise S. Vogt			Piffer	
ary	should and Mer s marke umatic	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailir	ng Address (Street and Number or Run			ip Code)
Ž,	and 2 ealth a n 27 is		James P. Marshall (son) 2051	Horseshoe Circ	cle, Jes	ssup, Md	20794
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Menlar Hygiene. If the file may 18 and Menlar Hygiene than "instural", or items 23a or 28a-f show or other traumatic event, the Medical Evanther must be rediffed at		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State	sition (Name of Instory or other place)	Date 20	c. Location - City or T	own, State
Ĕ	Pages ment of ant: If it		4 Donation 5 Other (Specify) Loudon P		5-08 Ba	altimore,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Fundal Service Licensee	2 Name and Address of Facility CCully—Polyniak Fu 204 Mountain Road,	neral Hor	me P.A.	d 21122
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent				Approximate Interval Between
· Lagge	Physician	1	Shock, or heart failure. List only one cause on each line. In rediate Cause (Final Isease or condition	1			Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	phomet			Comera
and it	Examiner	_	Sequentially list conditions.				
	sit sed	ıjne	Sequentially list conditions, if any keading to immediate cause. Enter Underlying Cause (Disease or injury			Î	
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8/60	our Se	dical E					
9	tificat ig phy as the	ledic	u				n-h
X R O	death certificate e attending physi d for use as the l	M/NE	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of deli	very
o E	e dea the att	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
J.	requires that the de been signed by the a nould be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the un	oderlying cause given in Part I	23e Did tobar	cco use contribute to	the cause of death?
Hecords,	signe d be o	d b	Taken Such Significant Contained to Contributing to death but not resulting in the til	deriying eddse given irri arti.	1 ☐ Yes		bably 4 🗆 Unknown
ဝွ်	w requir s been s should	ete			24a, Was an	-	
Ž	e fa has e 2	Completed			autopsy performe	d? prior to c	opsy findings available ompletion of cause of
	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical	26. Place of Deat	1 □ Yes 2 h (Check only one)	No 1 □ Yes	2 No
	S S =	To B	examiner? 1 ☐ Yes 2 A No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Otto		ce 6 Other (Spec	ify) Hospice
n ot	ding Phy h. After thi funeral o	ü	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how		
<u> </u>	tendi leath. tor: A the fu	cati	2 Accident investigation	M 1 □Yes 2 □No			
UIVISION	or At after c Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str	et, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
_	spital	S S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place,	and due to the cau	ise(s) and manner as	stated.
	n 24 h	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	vestigation, in my opinion, death occur	red at the time, date	e and place, and due	to the cause(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	, Day, Year)
	~		I hicholas land se lates mis	138500	W	lay lyth.	2008
į	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	1038500 He Patuxent Pawy	A	1111 000	ul
Ė	Stat	te	31. Date filed (Month, Day, Year) MAY 1 6 2008 32. Registrar's Signature	backer	COLLINIC	110 210	17
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			State Registrar				Ce	rtificate	of	Death		Reg. N	10. <u> </u>	18	15995	
	Physici /Medi		Decedent's Name	e (First, Middle,	Willia	ım Pat:	rick	Mı	urr	ay, Jr.	2. Date of I Month May	D	eay Ye	ar 8	3. Time of Death 5:00AM м	
	Examir		4a. Facility Name (/	f not institution,	give street and nui	mber)		4b. City, To	own, o	r Location of Deatl	1	4	c. County of [
H	Funeral	-	39 Glent 5. Social Security N		enue S. Sex	7. Age (In vrs	s. last birthday			onsville	8. Date of E	Birth	Bal 1		ace (State or Foreign	
	Funeral Director		219-26-64	180	1 ∑ M 2□F	68			Days	Hours Min.	8. Date of E (Month, Oct.	28,19	939 1	Count	land	
	land ow		Usual Residence of 10a. State	10b. County		10c. C	City, Town or Lo	ocation						10	d. Inside City Limits	
	a-fsh	ig	MD	Balti	more		Catons	ville							1 □Yes 2√ No	
	or 28	Dire	10e, Street and Nur			<u>'</u>		10f. Zip C		_		10g. C	Citizen of Wha		ry?	
	s 23a	Funeral Director	39 Glenw	ood Ave		adant Cres in 1	10 10	21228 Was Decedent of Hispanic Origin? (Specify Yes of					U.S.A.		- Indian	
ي	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examinar must be notified at once.		11. Marital Status 1 ☐ Never Marri	ied 2 Marrie	Armed Fo	2 No	s? If Yes, specify Cuban, Mexican, Pur ☐ No 1 ☐ Yes 2 ☐ No Specify:					NO-	Vhite, e	tc.		
003	ural",	d by	3 Widowed	4 L Divorced	Year or D	ates:						1	Specify: V			
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Baltimore, Maryland 21215-0036	be file tal Hy d othe event,	Be	17. Father's Name (Con				18. Mother's Nar						
<u> </u>	d Men narke	P			k Murray	, sr.	40. 14. 11			Carol		Entr:				
Ma	id 2 sh Ith an 27 is r traur		19a. Informant's Na		n Murray	/ Wife	1			and Number or Ru Avenue Ca						
<u>a</u>	s 1 ar of Hea item		20a. Method of Disp	position		20b.	Place of Dispo				Date		Location - City			
<u>ii</u>	Page ment c ant; If ury or				B □ Removal from : ecify)	State					16/08	Woo	odlawn	Cen	neterv	
3alt	permit. Depart Import any inj		21. Signature of Fu	4 Donation 5 Other (Specify) Lorraine Park Cemetery 5/16/08 Woodlawn Cemeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dunda-Ruck F.H. of												
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	Di	E 0	shock, or hea	rt failure. List o	nly one cause on e	ach line.		4	- 1	h :-		arrest,			Interval Between Onset and Death	
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(687)	ertifica ling ph e as th	Med	IF FEMALE:													
Box	eath c attenc for us	Physician/Medical	23b. Was decedent in the past 12	months?		come of pregr birth 2□Fet nant at time of	tal death 3	☐ Ectopic pre☐ Other (spec		у		i	23d. Date o Month		ry Day Year	
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	ss that gned l	by P	Part II. Other signif	icant condition	s contributing to de	eath but not re	sulting in the u	nderlying cau	ıse giv	en in Part I.	23e. Die	d tobacco	o use contribu	te to th	e cause of death?	
ord	requir een si	ted		Nysi	rupia	lem.	احت				1 [Yes	2 No 3 [rob	ably 4 Unknown	
Records,	e law has b ge 2 st	Completed		Hy	pent.	ensi	5				24a. Wa	as an topsy rformed?	prio	r to con	sy findings available apletion of cause of	
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Š	ysicla is cert direct	To B	examiner?		Hospital: 1 🗆	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DOA	Oth	26. Place of Dea er: 4 ☐ Nursing H			6 □Other (Specify	·)	
0	ng Ph fter th meral	D:nc	27. Manner of Death	h 5 🗌 Pending	28a. Date	of Injury th, Day, Year)	28b. Time o	f 280	c. Injur Worl	y at	28d. Describ				/	
Sio	ttendi death. :tor: A	cati	2 Accident	investiga 6 ☐ Could no	tion		town storm st	M		Yes 2 ☐ No	201	(0)				
Division of Vital	al or Al s after o I Direct d in by	Certification:	4 ☐ Homicide	determin	ed 286. Place buildi	ng, etc. (Spec	home, farm, st ify)	eet, factory, c	опісе		City or 7	_(Street a own, Sta	and Number o ite)	r Rurai	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical E	Physician: To the xaminer: On the b	best of my kr asis of examir ner stated.	nowledge, deat nation and/or in	th occurred at evestigation, i	t the ti	me, date and place	e, and due to the urred at the time	ne cause e, date a	(s) and mann and place, and	er as st due to	ated. the cause(s)	
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	Registr	ar	IV.	AY 16	2008	Aller Burg	K A	make 0								

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Pay **Physician** May Richard Moore, II George 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Franklin Square Hospital Center
5. Social Security Number 6. Sex 17 Aco //2 ---Examiner Baltimore Kosedale If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F **Funeral** 30 213-98-5868 Maryland 1978 Director Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Baltimore Co. Carney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9534 Burton Avenue 21234 United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 X Yes 2 □ No Specify: Spanish Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Joyce F. Panel George R. Moore 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health as Important: If Item 27 Is any injury or other trauonce. Mr. George R. Moore / Father 21234 9534 Burton Avenue Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park May 19,2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or s a consequence of): **Physician** disease or condition resulting in death) /Medical Due to (or Examiner Multiple Organ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner for use as the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been signe should be d 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 1 □ Yes this certificate 2□ No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Prive Boltimore, MD. 21237 Dr. Stephen Selinger 9000 Fro State 2008 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 2008 LENE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALTIHORE ROUND If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrş. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Min. 219-40-863 1 ☐ M 2 🔀 F Director AND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) +HGRADE HSSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MORTON TRINA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sonatur of Funeral Service Licensee 23a /art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. In predicted Cause (Final sease or condition resulting in death)

a. Characteristic forms are condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner wronau ar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a on equence of): Examiner 1064640 burial-trar Due to (or as a consequence of): Box 68760, physician pe Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month ξ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate 1∐ Yes 2**7** No 25. Was case referred to medical examiner?

124 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier Medical (Check only one)

Division or Vital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 63 1 6 32/Registrar's Signature 31. Date filed (Month, Day, 2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OOA M May 13 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NorthWEST Kandallstown Baltimore if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6.56 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Days 1X M 2□F Hours Director 262-63-6702 40 10-14-1967 FLORIDA Usual Residence of Decedent 10c. City. Town or Location 10a State 10d. Inside City Limits 10b. County 28a-f show a or 28a-f sho be notified a 1 XYes 2 No Director BALTIMORE WINDSOR MILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3229 CARLSWOOD CIRCLE 21244 USA Itеms 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed er than "natur, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-LABORER CONSTRUCTION -0-Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BEN McMILLER SR. LILLIE McCRAY ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 3229 CARLSWOOD CIRCLE WINDSOR MILL, LATASHA McCRAY (SISTER) MARYLAND 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of h Important: If its any Injury or o once. 1 Burial 2 Crematic 3X Removal from State EDGEWOOD CEMETERY 5-16-2008 APOPKA, FLORIDA 4 Donatio 5 Other (Specify) Vensee JONATHAN HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat use (F disease of ndition resulting in eath) use (Final **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) by the a ☐Yes 2☐No 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed death? 1 ☐ Yes 2 ☐ No certificate 2 100 Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Impatient P 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Naturai 5 Pending investigation s after death.

If Director: A

cd in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined n 24 hours aft ne Funerat D bletely filled ir 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

Registrar

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

5401

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAY 1 6 2008 DHMH 17 Rev 1/2001

0/d (

29c. License number

29d. Date signed (Month, Day, Year)

Pourt Road, Randallstown, MD 21133.

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0										111	
			Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year 3. Time of Death				Death	
64	Physici /Medi		SOLOMON MARSHALL					MAY			10 2008 8		рМ	
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. Ci	ty, Town, or Lo	ocation of Death		4c.	County of Deat	h		
- Alley			FUTURECARE LOCHEARN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur					BALTIMORE f Under 1 Year If Under 24 Hrs. 8. Date of			Birth 9. Birthplace (State or Foreign			
3	Funeral Director		2	1 M 2 □ F	` *	Yrs. Month		Hours Min.	(Month, Da	ıy, Year)	Co	intry) RYLAND	roreign	
60.			Usual Residence of Decedent		02				DEC 13	172	3 111			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State 10b. County 10c. City, Town or Location								10d. Inside Cit	•		
			MARYLAND N/A BALTIMORE											
		Ö	10e. Street and Number 10f. Zip Code							10g. Citi	zen of What Co	untry?		
d 21215-0036		Funeral	2121 WINDSOR GARDEN RD APT 532C 21207 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe						pecify Yes or No)-	U.S.A. 14. Race - Ame	rican Indian,		
								o Rićan, etc.)						
		l by	3 ☑ Widowed 4 □ Divorced Year or Dates: 32/34							Specify: BLACK				
		etec	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						king	16b. Kind of Business/Industry				
		Completed	Elementary/Secondary (0-12) College (1-4or 5+) 6 th grade LABORER							SELF				
		Be Cc							e (First, Middle	irst, Middle, Maiden Surname)				
<u>la</u> n		To B	JOHN C MARSHALL BESSIE I						P BRIG	P BRIGGS				
Maryland			19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Addre	ess (Street and	d Number or Ru	ral Route Numb	er, City o	r Town, State, 2	Zip Code)		
			Thelma Davis/Nie	ece			_	ge ct.,						
ore			20a. Method of Disposition 1XXBurial _ 2 □ Cremation 3 □	☐Removal from State	20b. Place of cemeter	Disposition (f ry, crematory o	vame of or other place)		Date	20c. Lo	cation - City or	Town, State		
Baltimore,			4 □ Donation 5 □ Other (Speci		BALT	O NATIO			3-08	BAL	TIMORE,	MARYLA	.ND	
Bal			21. Service Ucenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE											
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caused one cause on each lir	the death. Do r	not enter the m	node of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Bety	ween	
			Immediate Cause (Final disease or condition a Metastatic Adum Carcinous UNK)								n & /	MOM		
			resulting in death) Due to (or as a consequence of):						A O II	Jane A.				
		ja l	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	Due to (or as a consequence d):					James				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	F	Failure to thri			UR			4 weeks			
			resulting in death) Last	Due to (or as	Due to (or as a consequence of):									
58760,		dical	<u>g</u>											
		Mec	IF FEMALE:	220 If you outnome	of prognancy									
Вох		Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	ic. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pi 4 ☐ Pregnant at time of death 5 ☐ Other (sp			opic pregnancy er (snecify)			23d. Date of delivery Month Day Year			
0			1 Yes 2 No 9 Unknown					pecity)						
S, P		by Pt								23e. Did tobacco use contribute to the cause of death?				
rd		Completed b							1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown					
000									24a. Was an autopsy findings avail prior to completion of cause					
<u> </u>		l G		pe 1□ Yes							rformed? death?			
/ita		Be	25. Was case referred to medical examiner?	Heavitale Otto Annual Control										
or Vital Record		은								ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
on		tion	27. Magner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined						aca. December ion injury december					
Division		fica							28f. Location (Street and Number or Rural Route Number,					
Ö		Certification:	building, etc. (Specify) City or Town, State)											
		Medical C)	
			29b. Signature and title of certifier 29c. License number							29d. Date signed (Month, Day, Year)				
	0		DO059014						_	5/13/08				
1	()		30. Name and ress of person who		eath (Item 23a)	Type, Print)	~ ,	4011		Λ.		111		
1			Suy	PARK	Jan	D 1	00 W	HSH IN	KITON	BL	ND	INP 91	230	
70	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 6 20	NR SACHEGISTA	ar's Signature	10	-							

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